Review of the Modern Trend of Nursing and Nursing Education

By KATHLEEN W. ELLIS*

A subject worthy of much discussion is suggested by the title of this paper and it is a privilege to have the opportunity of introducing it upon an occasion such as this, when all those most vitally concerned in the solution of its problems will be represented.

Nursing today may be classified as bedside and community nursing.

The term bedside nursing is understood to include all branches involved in arranging for the bedside care of the patient: institutional and private duty nursing, as well as teaching and administration; while community nursing embraces public health, social service, industrial nursing and the various types of preventative work.

A few years ago the bedside nurse was, as the term implies, one immediately concerned in the bedside care of her patient, her responsibility extended to assisting with the routine work of the ward and incidentally preparing herself to impart instruction to others. Most of her knowledge was gained from her practical experience on the ward, there was little, if any, class room instruction. It was not until some years after training schools were established that the private duty nurse came into existence, and at first her duties were carried on under the direct supervision of a medical student who remained in the home and performed many of the services now delegated to the special nurse. Changes have taken place gradually and what a contrast the situation of today presents, with the increasing tendency to place more responsibility on the nurse. Not only is the nurse expected to have a thorough knowledge of the general care and treatment of patients, technique, etc., to a far greater extent than heretofore, but she is required to be familiar with special treatments and tests, which with rapid advancement in medical science have come to be regarded as part of the daily ward routine. These not only absorb a great deal of the time and attention previously devoted to the actual care of the patient but call for additional instruction, if the student is to have the required understanding of such procedures as: fractional test meal, lumbar puncture, aspiration, and the various kidney and blood tests which necessitate such careful and constant attention on the part of the nurse, who, in addition, is to be prepared to undertake the keeping of accurate records, now regarded as such an essential part of hospital routine.

We cannot deny that the present day student, who goes out from the training school properly equipped to meet the demands made upon her, must have acquired during her course of training, knowledge of a technical nature and otherwise which nurses some years ago gained only by hard-earned experience, often obtained after graduation.

In addition to this, much more frequent are the calls for nursing "specialties." Repeatedly does the request come for a nurse who understands the care of diabetes, is conversant with metabolism work and the administration of insulin, one who is proficient in the nursing care of eye, ear, nose and throat cases, who has had experience in radium treatment or X-ray, and so on. Nurses are today being called upon to fill positions which but a short time ago

(*Read by Miss K. W. Ellis, Superintendent of Nurses, Vancouver General Hospital at the B.C. Hospitals Association, Vancouver, September 9, 10 and 11, 1926.)

were closed doors to them; may not this be recognized with appreciation as an indication of the increasing faith in the ability of the nurse on the part of the medical profession?

Just how much special training should be included in the general nursing course is a subject of controversy and must necessarily be somewhat dependent on conditions which exist in the individual training schools. It is, however, generally considered that while these must be classified as "specialties," a student should have some knowledge of the theory of X-ray, massage, physiotherapy, anaesthesia, urine analysis, and various laboratory tests, in addition to the general nursing subjects, in order that she may give intelligent co-operation in obtaining the required results. Mental hygiene is also a subject that has of late years been felt most essential to add to the nursing curriculum. The need for preventative medicine is emphasized more and more in all branches of work and nurses are constantly being called upon to aid the physician by assisting in teaching and advising the public; although this subject is being extensively dealt with in schools today, does not the opportunity of giving further instruction frequently fall to the lot of the pupil as well as to the graduate nurse?

Community nursing in all its phases is a work for which special training is essential, and in spite of this fact it is absorbing many of our nurses today. Doubtless because it affords such wide and diversified opportunities of interest and in addition presents the probability of more attractive living conditions, shorter hours, higher remuneration, than available to those who have not had the benefit of special training, and also allows for more freedom from responsibility in hours off duty.

Fifteen years ago an eminent physician, when speaking to a group of nurses said, "On looking over the history of nursing, I have been very much struck with the rapid expansion of the work intrusted to nurses. Anyone who works in a hospital realizes that transfer of routine from the physician to the nurse is still going on and this may account for an occasional misunderstanding perhaps, as to what is a nurse's duty and what is a physician's." This same physician added. "Thus far, nurses have, for the most part, been content to be general practitioners of nursing, but already some have begun to specialize, and it needs only half an eye to see that the near future will be marked by an extension of this tendency to specialize in nursing. The time is fast approaching when we shall have nurses who attend chiefly or solely obstetrical cases, others who care only for pediatric cases or for nervous and mental cases, only for fever or operative cases, and so on. Nurses who desire successfully to specialize will be compelled to acquire unusual training and experience just as is the specialist in medicine." This propheey did not, and could not, include the world-wide changes that were to be wrought by the great war, changes which so materially affected all organizations, but most essentially the medical and nursing. Its fulfillment, however, is the answer to the question so often asked as to the necessity for increase in the curriculum taught in schools of nursing. The attempt to carry out a standard curriculum with all the changes and advances in nursing education is today occasioning much discussion and deeply perplexing those who are responsible for its application. It is impossible for those immediately concerned with hospital administration to be indifferent to the fact that an ideal solution of the problem has not yet been arrived at.

Many suggestions have been made to further this end. It would, however, be a digression from the subject of this paper to enter here into any detailed discussion of this phase of the question, but mention may be made of the shorter course for nurses, group nursing, consecutive

eight-hour duty, employment of nurses and ward assistants for general duty to relieve the student of much of the routine work of the ward; it has even been predicted that the day may come when schools of nursing will be as schools of medicine, when the student nurse will no longer be an apprentice in any sense of the word. Nursing education is undoubtedly undergoing a process of evolution and it is apparent that many of the solutions suggested involve the question of finance. Schools of nursing require support and surely are just as much the responsibility of the community as are schools established for other educational purposes. Can the hospital be expected to bear this responsibility as well as finance the general working of the institution?

It is most true that the immediate problem of the hospital is the care of the patient of **today** but it also includes the care of the patient of **tomorrow**; the necessity of this is recognized in a measure by the emphasis being placed upon the research work carried on in the laboratories which exist in connection with all the larger institutions. Just as much does this obligation apply to the preparation of the **nurse** of tomorrow. In caring for the sick of today and tomorrow, the object for which the hospital exists, the education of the student is not a secondary consideration and is one which must be accomplished without sacrifice on the part of the patient.

There is no doubt that nursing, as well as other conditions of life, must inevitably be affected by the trend of modern times—is not the profession at this time suffering in an attempt to meet some of the rapid changes? To keep alive these changes, to be ready not only to make the necessary adjustment today, but to be prepared to meet the conditions of tomorrow is the responsibility of the profession and in order to enlist sympathetic consideration of their problems nurses must now and always cherish their standards and ideals and render good and faithful service. Then for the future there need be no fear.

Red Cross Radio Talks on Home Nursing in Nova Scotia

Miss Elizabeth O. R. Browne, R.N., the provincial organizer of the Red Cross Home Nursing Classes in Nova Scotia, has recently followed the excellent example set last year by Mrs. H. M. Conquest, of the Alberta Red Cross, who introduced in that province periodical radio talks by experts as a means of sending broadcast and in attractive forms all details with regard to the peace time programme of the Red Cross for higher standards of health in Canada as well as practical advice on home nursing courses and how to obtain them.

Interesting facts mentioned by Miss Browne in her talks to date were that in answer to many earnest appeals for elementary instruction in home nursing, the Red Cross Society had prepared a manual on this subject and had laid plans for instruction classes all over the Dominion. Up to the present time some 10,000 women and girls have availed themselves of this opportunity, the classes are everywhere becoming increasingly popular and in Nova Scotia nearly two thousand women and girls have taken the Home Nursing Class instruction.

In other portions of Miss Browne's addresses she touched on the constructive health work being done in the Red Cross Seaport Nurseries, in the Public Health Nursing courses and in the thirty-seven Nursing Outpost Hospitals now in operation in remote districts in Canada, which have been instituted and conducted as part and parcel of the peace time programme of the Red Cross.

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On to Pekin! Follow Your President to China

By CORA E. SIMPSON, R.N., General Secretary, Nurses Association of China

I am sure that is just what a fine lot of the Canadian nurses are already planning on doing in 1929. Peking, you know, is one of the most interesting cities in the whole, wide world. Camels, automobiles, carts, wheelbarrows, carriages, horses, sedan chairs and rickshas all jostle together on the streets. Jade, tapestry, laces, embroidery, silks, amber and all other kinds of pretty things look out at you from the little shops along the sides of the narrow streets. Pagodas, temples, the Great Wall, Ming tombs, Temple of Heaven, summer and winter palaces: don't you want to explore them? Won't it be exciting to drink real China tea and to attend a real Chinese banquet and to see and hear real Chinese drama and music? You will be interested in meeting our splendid Chinese men nurses and our tiny women nurses. You will be sure our bright-eyed babies are the most adorable in the world.

China is only fourteen days away from Vancouver on the splendid Empress boats of the Canadian Pacific Line. The second class is very comfortable and surely within the reach of many.

It is anticipated that the cost of the entire trip will be about one thousand dollars. Those who wish to travel first class will have to plan on more than this amount.

First Itinerary. — Time about 45 days; approximate cost $700. This trip takes one by steamer from Vancouver to Japan. By rail through Japan, Korea, and North China to the Congress. After the Congress through inland China by rail to Hankow and steamer to Shanghai, and then by Empress steamer back to Vancouver. Time to visit chief points of interest at all places.

Second Itinerary.—Time about two months; approximate cost $800. Steamer from Vancouver to Japan, China, Manilla, Hongkong, Canton, and Shanghai. River trip to Hankow. Rail to Peking. Congress. Rail through North China, Korea and Japan. From Yokohama by steamer home again. Sight-seeing and visits to chief points of interest.

The trips will be in the care of a personal conductor "from the time the steamer leaves the home port until it docks at home again." He will care for all travel, hotels, money and the business of the trip.

The official language of the Congress is always English, so you should feel much at home. Our Hospitality Committee are planning to entertain you in the Yen Cheng University now being erected in Peking. Some of the Canadian nurses you will meet are: Miss Caroline Wellwood, who has translated Aikins Ethics for our schools; Miss Barbara McNaughton, superintendent of nurses at Chungking, Sze; Miss Geraldine Hartwell, superintendent of nurses at Chengtu, Sze, who is the author of English-Chinese Conversations for Nurses; Miss Katherine Ross, of Chengtu, author of "Hospital Technic"; Miss Susan Haddock, superintendent of nurses at Tzeliutsing, Sze; Miss Batstone, Mrs. Ratcliffe, Miss Mitchell and many, many others who are making their wonderful contribution to the nursing and health of China, and of whom you should all be very proud, as we are in China.

In the north-west of China is the Province of Kansu—as large as some of the largest provinces of Canada—and there is only one hospital in the whole province and no nurse at all, as yet. We are hoping that some of you will not only come over to see us but decide to stay and help us build up nursing in this Rainbow Banner Republic of the East, where the need for nurses is so great and where the love of a great people is our reward and crown.

Editorial

Solving the Cost of Nursing Education

Lack of funds is so often cited as one of the great obstacles to the development of nursing schools that the question may well be asked, "Why should nursing education stand alone as the one type of 'essential' education receiving no public aid?" How long must the hospital patient have included in his account for nursing service a proportion of the cost of the education of the students? Why should the sick public bear an undue share of this educational cost?

Let us look, too, at the implication, in the continuance of the apprenticeship system, that the student spends a longer time in ward service than is essential for her training. If the full three years is essential to the training of a nurse, why then do we add to the cost of education by the payment of a monthly allowance? It might very well be said that the uniform and regulation footwear is really equipment which would not be required apart from the hospital, but such might well be provided at a considerably smaller cost than the allowance now made in many schools.. Why continue an allowance to nursing students when in other centres of learning the students pay a tuition fee?

Nurses' homes are built, equipped and maintained at a very considerable expense, but certain exigencies of the situation—early, late and irregular hours for changing duty, and other considerations—seem to make it almost a necessity that these should be maintained. If training schools would agree upon a reasonable estimate of the cost of maintenance and education of each student, and if they would also agree as to a reasonable tuition fee to be charged to pupils, then through the proper avenues present the situation to educational authorities, could not grants be obtained for this as for other forms of education?

The difficulty to be met with in the small school will probably be advanced by some, but when it is remembered that the sum accruing would probably make possible the addition of another member to the teaching staff, it will readily be acknowledged that the small institution would probably then be the more justified in attempting to maintain a school.

And what a burden would be lifted from the shoulders of the finance committee of hospital boards if the expenses of nursing education might be met from sources apart from the grants and fees paid for the nursing care of the patients! What a burden lifted from the shoulders of the director of the nursing school if she were no longer made to feel that money used in the development of the nursing school is badly needed for maintenance or development of some other department of the hospital! Upon what other group of people is laid such a burden as that borne by the board of governors and the administrative body of the hospital and nursing school? If such an adjustment would lessen the burden, surely an adequate presentation of the problem would bring relief.

Many new plans in nursing education are being tried out. Is it not agreed that the apprenticeship days are over, and that the nursing profession requires of the young woman of today just as careful a preparation as that for any of the other learned professions; that at the same time it offers to her a vocation which gives scope for all her energy and ability, and which will satisfy her every ideal of service to mankind? Having faith in the present and future of our profession, we need not fear any shortage in the right type of applicant when we place nursing education upon the same basis as other types of professional education.

Art as Applied to Medicine

By HARRIET BLACKSTOCK
Artist in Charge, Department of Art Applied to Medicine, McGill University, Montreal

Art as applied to Medicine, the title of a school in Baltimore and the name given to a service which is being found an invaluable adjunct to medical science today, though so descriptive in itself as a title, is provocative of many inquiries as to its exact nature by those hearing of it for the first time. And it is in answer to the interest of those wishing to know more about the work carried on under that title that this short article is being written.

"Art as applied to Medicine" was chosen in 1911 as the title of a school which, by the generosity of an anonymous friend, was to be endowed at Johns Hopkins Hospital, where under Professor Max Broedel should be taught the application of artistic principles to medical illustrating and the pictorial needs of the medical profession.

Max Broedel was then, as he is still, the leading medical illustrator on this continent, and it was felt that it would be of great value to the profession if his experience, his technique and general understanding of the problem could be made available for the education of others, who would carry on the work and generally improve in time the tone of medical illustrating in this country.

Artists till then had to overcome, each for himself, the many problems incidental to the particular nature of the work, without the benefit of the past experience of others. At Johns Hopkins Hospital the all-necessary anatomical and medical knowledge is supplied that, apart from artistic skill, makes an intelligent interpretation of the doctor's work possible; also the facilities for acquiring familiarity with the operating room and the surgeon at work. Although a detailed account of the students' work there might be of interest, it is more with the nature and uses of medical illustrating that this article deals. The doctor knows how often his paper calls for something more than a micro-photograph or a chart, the accuracy and detail of which is of the greatest importance, but which calls for no artistic ability. He wants to show more vividly than by words alone, or to express in colour, the condition found in the case of operation under discussion.

The student knows how much help he has got from his text book with the "decent illustrations," or how in the anatomy book the illustrations have created in his mind a picture of the topography that the text alone, with its at first unfamiliar names, has failed to do.

And the nurse—what of the anatomical charts, et cetera, incidental to her training? They all know and appreciate to some extent what medical illustrating has done for them.

But the layman is extremely interested too. Undoubtedly someone is asking that question which so often follows some explanation of the work. Why not photograph? Surely it is more accurate, cheaper, et cetera. It is a quite legitimate question and there is a reasonable explanation of why in most cases the services of a trained artist are of more use than those of a photographer.

In the first place, there is the question of the viewpoint and the lighting. Often the artist has to piece together the course of an operation from very meagre views, by the aid of a knowledge of the anatomy of the field, and an ability to interpret the surgeon's actions. In a deep incision, where the field may be

partially obscured by bleeding or merely by swabs, retractors and numerous instruments, the camera has small chance of taking away as descriptive a picture as the quick eye and retentive memory of the trained artist. But what of the specimen? Can't the camera with the aid of correct illumination do as well here as the artist? In many cases, yes, but how many have seen a specimen that has been of the greatest interest to half a dozen men who have all "had a look at it" before the necessity of keeping a record of it has been considered or before it was possible to hand it over for that purpose? The pathologists have had a slice of it here and another section of it there. It has been dissected and cut into somewhere else, and what the doctor wants is not a picture of a cut-up shrunken mass out of a jar of formalin, but of the specimen as it was, *in situ*, or immediately on removal at operation.

There is still plenty of use for the camera and it is foolish to occupy an artist with work which the camera can do, but equally silly to expect a camera to be able to do the work of an artist especially trained to give to each detail its true value.

That brings us to *the* important thing in medical illustrating. The picture must show at a glance the point which the doctor wishes emphasized, the rest must be subordinate to that, though much more than the camera would bring out must be there to supplement the story. Shadows must not obscure, but the whole must illustrate or throw light on the subject.

Having demonstrated the necessity and usefulness of an artist to the medical profession a list of some of these uses might be interesting. For the surgeon there are the sketches taken during operations to be worked up later to show the successive stages in his technique, for the use of his confreres or for some text book. Illustrations, too, of some particular case of unusual interest for record, or to be presented later when a lantern slide of his findings will surely help; or again, in the ordinary or typical case to be used for teaching purposes. For the medical man, or radiologist, there is the typical or again the unusual case, the record of colour which is so ill expressed in words, or that of definite stages of progress in some case under special treatment.

The otolaryngologist has many an interesting case. It may be a view down a bronchiscope or up the nose, where one could hardly expect a camera to be of much help.

Eye work is also an interesting branch of Art applied to Medicine. There is considerable colour work, and it calls for such accuracy in the mental picture, as it must be built up from the sometimes very limited views through the opthalmoscope or slit-lamp. The latter, through which is studied the microscopy of the living eye, opens up a large field in itself. The microscopic drawings have not been mentioned nor the incidental needs of every allied branch of medicine.

The work itself is varied, and the techniques from pen and ink to colour are varied too. It is a large field with an almost unlimited scope for development. The appreciation of its definite contribution to medicine is growing and should be met by a stimulated endeavour on the part of the artist. An aptitude for drawing, a sufficient knowledge (however acquired) of anatomy to enable the artist to take an intelligent interest in, or enable an understanding of the doctor's work, are first principles of medical illustrating. But an ability to develop one's technique and skill and above all benefit by continued experience is essential to suc-

cess,—interest and ever-increasing interest, too.

Each new case, each new problem lifts a corner of the curtain emphasizing the smallness of one's knowledge compared to the vastness of the many fields touched upon, yet medical illustrating has a definite contribution which it can make to each, and it is the added quality which this highly specialized work has, and the definite improvement in modern medical illustrating, which justifies the application of Art to Medicine.

The Edith Cavell Memorial Home Toronto Western Hospital

By CHRISTINA MacLENNAN, Reg.N., Supervisor of Nurses' Home.

Some years ago (previous to the Great War) an energetic body, the Women's Board of the Western Hospital, represented by Dr. Stowe-Gullen, began to work for a new nurses' home, and today, after a strenuous campaign and years of labour, their dream has come true—the building is completed and occupied.

Quoting Mr. Galbraith, the superintendent of the hospital, "The aim kept constantly before us, in planning and completing the new Edith Cavell Memorial Nurses' Residence, was to create an atmosphere which in every detail of furnishing and decoration would be as far as possible from that of the hospital." The Hon. David Fasken's gift and generosity to the hospital made possible the carrying on of the work, and every visitor will admit, this ideal has been realized.

The building, providing facilities for study, rest and recreation, is eight stories in height, and so situated that sunshine is freely admitted into every room and corridor.

On the completion of the building, it was thought by all vitally interested, that their ideals might best be achieved by procuring the services of a competent decorator, one who would be free to study the wishes and needs of all concerned in the planning of the home. To this fact is attributed wholly the spirit of charm and appeal, so noticeable in every detail.

The furnishings are the result of good taste and thought, rather than the expenditure of large sums of money. From the first, it was the idea to bring nurses, wearied by the care and anxiety of the sick, into rooms where the imagination—and often, the artistic spirit, which is inherent in most people—would be stimulated. From such an atmosphere, should they not return to their hospital duties more capable and efficient in every way?

Will you join us in a tour of inspection? Entering the spacious reception hall, one immediately notices the handsome bronze tablets, placed on soft-toned stucco walls: one, to the memory of Edith Cavell, and the other to the nurses of the joint Alumnae who served overseas. Persian rugs and a few pieces of good Jacobean furniture complete a hall at once inviting and perfect in its appointments.

The large living room at the south end of the main floor with its handsome fireplace, grand piano, cosy chairs and chesterfields, all harmonized in soft shades of mulberry, gold

and rich browns, is the room where graduates, seniors and probationers mingle and enjoy many happy hours.

Passing down the hall, one turns into a couple of small adjoining reception rooms, the furnishings the gift of a lady whose thought and time have evolved perfect little gems of colour and art.

Adjoining these, and forming a vista, and in perfect value, is the library. This room has hangings of rich crimson velvet with gold background, soft taupe carpet and bronze painted walls. Piranesi etchings, wrought-iron electric fixtures, walnut bookcases and furniture with crimson upholstery, all tend to create an atmosphere both academic and restful.

The private suites of the principal of the training school and her assistant have not been forgotten in the general scheme of the home, for on these nurses and their staff depend so much of the success of the hospital and school for nurses. On the first floor is a suite for the principal. The living room is rich in colour, but so restrained that its usefulness is not impaired. A soft grey carpet, wall paper of rich design, gold silk hangings, charming shades and cushions of colour have provided an atmosphere of home and individuality. The adjoining bed room with its grey walls, rose hangings and shades, poster bed, and period table, is daintiness itself.

The assistant's suite is situated above, and is equally attractive in a colour scheme of blue and gold.

On entering the dining-room one is at once impressed with its beauty and cheeriness. Simplicity of furniture which is lacquered green and red, with Windsor chairs, Welsh dressers, and beautiful hangings of linen, bright with colour, give this room a character all its own. Truly, sunshine and cheeriness are the keynotes here, and furnish a suitable atmosphere in which to begin the day.

A nurse's bedroom is essentially a bedroom—in all its details the ideal of a dainty and well-brought-up girl —with a dressing table and desk of walnut, and a simple but good looking steel bed in walnut finish. Colour schemes of pink, mauve or gold, are carried out in fascinating cretonne curtains, coloured bed spreads with Mossfield blankets and rugs, electric shades, and other details in harmony.

On each floor is a sun room for informal use, each having its distinctive colour scheme. The one on the second floor is used solely by the supervising nurses. Here soft shades of taupe, blue and rose, painted linen hangings, lovely lamps and good prints, complete a room where dignity and usefulness predominate, yet which lends itself to the charm of afternoon tea or a quiet game of bridge.

The eighth-floor sun room is an outstanding feature, following the style of Chinese decoration—an ornamental black rug, soft green walls, rich lacquer-red reed furniture, upholstered in black mohair satin, with gay black cretonne hangings, which gather up and harmonize all the colours in the room. This room, with all its gay yet restrained colours seems to vie with the setting sun as one gazes westward over the city.

The other five sun-rooms in their various hues of green, blue, orange and rose, are equally beautiful.

As a visitor remarked, the home is complete, even to having a hostess, for always one is met by a nurse whose duties are to look after the home, its occupants and guests.

(Editor's Note: It is regretted that several illustrations for this article were not received at the time for going to press.)

Certain Points in Handling Trachoma

By Dr. W. HARVEY SMITH, Winnipeg

Trachoma is an inflammation of the conjunctiva, which originates by infection, and produces an infectious purulent secretion. It is distinguished principally by its chronic course in which it develops a hypertrophy and consequent roughening of the conjunctiva. Both eyes are nearly always involved, but exceptions are found. Patients complain of sensitiveness to light, of lacrimation, and of sticking together of the lids. Pain and visual disturbance are also often present. Upon everting the lids the conjunctiva of the tarsus and also that of the retrotarsal fold is found to be diffusely reddened and thickened, its surface at the same time becoming uneven in varying degree. In advanced cases cicitrization of varying degree is observed. Pannus and ulcers of the cornea are frequently present and account for defective vision. Persons may be the victims of trachoma without complaint of any ocular trouble. Acute symptoms are comparatively rare, trachoma being essentially a chronic disorder.

The importance of recognizing the origin of trachoma cannot be too strongly emphasized. Thus it originates exclusively in infection proceeding from another eye affected with trachoma. Infection takes place by transfer of the secretion. Since it is the secretion alone that transmits the infection, the danger of infection is in direct proportion to the amount of the secretion. The transfer of the secretion from one eye to another generally takes place indirectly through the medium of the finger, or when any articles, such as sponges, towels, handkerchiefs, etc., are brought into contact with the eyes. Especially is this likely to occur when numbers of people have their sleeping apartment in common, and make common use of the articles above mentioned. Overcrowding, bad air, and irritative conditions, such as dust, etc., are predisposing causes. Where it is known that certain racial groups are predisposed to trachoma, the foregoing is doubly important.

It is impossible to determine precisely the treatment required in a given case without an opportunity being afforded of making an examination, but it is suggested that treatment commence with a mild tannic acid and glycerine preparation, the strength of the ingredients being increased as tolerance is displayed. Thus tannic acid can be employed from ten to sixty grains to the ounce with glycerine from half to four drams to the ounce. Direct application to the everted lid of a 2% solution of nitrate of silver is a recognized method of treatment; also direct applications of solid copper sulphate. Where acute symptoms develop (oedema, photophobia, etc.) it may be advisable to secure accommodative rest by employing a solution of atropine sulphate, gr. two to four to the ounce, twice daily. Hot bathing with boric acid solution should be employed two or three times daily, not only for the sake of cleanliness but for the sedative effect of the heat. After bathing the eyes or handling them in any way, the hands should be washed and scrubbed, preferably in running water.

Coloured glasses should be worn in order to protect the eyes from wind, dust, smoke, and strong light.

(From the Manitoba Provincial Board of Health Public Health Nurses' Bulletin, July, 1926.)

No tight-fitting dressings, shield or mask should be worn, as such interfere with drainage and tend to make the underlying structures soft and soggy, and less resistful of bacterial action. It should be explained to patients that treatment will be a long and tedious matter, and the results obtained will be proportionate to the faithfulness with which it is carried out and the principles laid down are observed. The importance of each individual using his own towel, pillow, etc., should be stressed.

From the foregoing it should be possible to evolve a set of principles relating to treatment and prophylaxis that will be easily understood by patients and which will yield satisfactory results in the cure and control of trachoma.

Corrections: It is regretted that through an error the name of Miss Kate S. Brighty, Reg.N., as writer of the article on The Development of Hospitals in Alberta, The Canadian Nurse, January, 1927, was omitted. Also that Miss Lexa Denne, who contributed the paper on The Visiting Housekeeper, is not a graduate nurse but is a graduate in Arts and Household Science, University of Toronto.

We Have Left Undone

It's not the thoughtless, selfish things you do
That twist the heartstrings till their throbbings cease,
Nor yet your stinging tongue that causes love
To beat its drabbled wings and beg release.
That love for just a smile would live,
But that's the smile you didn't give.
Your sharp retort would go unheard
For just one little loving word,
Or else a pressure of the hand
To whisper that you understand.
Just this—a paltry price to pay—
Yet stubbornly you tramp your way.
It's not the heartless things you do or say,
It's just the things you left undone to-day.

LUCILE TOPPING HOWELL.

Generalized Public Health Nursing on Vancouver Island

By ISABELLE M. JEFFARES, Reg.N.

The district on Vancouver Island known as the old Cowichan Electoral District is in many ways very like England. Not only do a large number of the residents hail from the Old Land, including many army and navy veterans and their families, but the climate is similar in many respects. The district extends from Shawnigan Lake in the south (a holiday resort for Victoria, which city is twenty miles away), up to Chemainus, a very active mill town, approximately twenty-five miles north. The western boundary, Cowichan Lake, is a small hamlet in the midst of great timber limits, a rendezvous for loggers and other men of the woods. On the eastern side there is the salt water, Cowichan Bay, Maple Bay, and Osborne Bay, with the Genoa Bay Company mill and school. In all, the district extends approximately twenty-five miles north and south and about the same distance east and west.

The population of this section of the country is about 6,000, not including the casual labour employed in the mills. There are fifteen one-room rural schools, a four-room school at Chemainus, and a thirteen-room consolidated and three-room high school at Duncan, accommodating in all about 1,000 children.

In September, 1919, the Cowichan Women's Institute, working in conjunction with the Duncan Consolidated School Board, appointed a nurse whose duties included school inspection and general nursing. In October, just a month later, the Cobble Hill and Shawnigan Lake Women's Institutes appointed a nurse on probation with similar duties. It is interesting to note that the movement to obtain a nurse began almost simultaneously in the town and country, and that in both cases it was sponsored by the Women's Institute. The results of both experiments were satisfactory, but the continuation of the service depended on financial support, and it was decided to form an organization that would include the whole district.

The Red Cross Society was at that time carrying on, endeavouring to work out their peace-time programme, and all branches in the district joined forces and loyally worked together in the support and organization of the health centre. In this they had the support and sympathy of all the women's organizations, i.e., the Women's Institutes in the various parts of the district, the King's Daughters, local chapters of the I.O.D.E., and in addition the city of Duncan and the municipality of North Cowichan make generous grants yearly. Help is also received from the Department of Education in annual grants towards the salaries of the nurses and from the local School Boards at the rate of a dollar per pupil in the schools inspected by the Health Centre nurses. Also, the public is given the opportunity of demonstrating its appreciation and support of the work in contributing to the annual drive for funds held in November.

In such a large, sparsely-populated district the great difficulties in attempting a generalized service were that of transportation and providing a central office. The first difficulty is surmounted by supplying the nurses with Ford cars, and the second by obtaining an office in a centrally located building in Duncan, the natural centre of the district.

During the past year the nursing service of the Health Centre has increased greatly, more than doubling that of the previous year. In all, over 3,300 visits were made to homes in the district, and of these 1,975 were bedside nursing visits when actual nursing was done. Four hundred and eighty-four tuberculosis and other welfare visits were made. Phone consultations numbering 1,410

were held and 546 visitors were received in the Health Centre. Two hundred and twelve transportations were made by the nurses with the Health Centre cars, including many patients from all parts of the district, who, unable to afford ambulance transportation, were brought into the hospital by the nurses at the request of the doctor or the patient's family.

All babies known by the nurses to be living in the district are visited as soon as possible after birth, and monthly from then on. Eight hundred and sixty-four such visits were made in the past year. It is the desire of the Health Centre to establish a record of all babies in the district, to visit them when possible during the pre-school period, and to continue the record until it is replaced with the school health record. A Well Baby Clinic is held monthly in Duncan, the local medical men taking turn in giving their services. A member of the Women's Institute serves tea to the mothers. The clinic mothers, usually young and more or less inexperienced in child care, become very good friends.

The Health Centre does not administer material relief to families in need, but as always throughout the world sickness and poverty are closely connected, the nurses have an intimate knowledge of the home and economic conditions of the different familes, and are asked by the different organizations handling relief to investigate for them. During the year ninety-one cases were investigated and reported upon.

All the children attending school in the district are examined yearly by the different school medical officers appointed by the Board of Health. The records of the annual physical examinations are filed in the schools, and when children are transferred from one school to another their school health record goes along with them. There is an individual class-room inspection of each child once a month by the nurse, and in case of an outbreak of communicable disease in a school the children attending that school are inspected daily until all danger of communication is over. The signs and symptoms of the communicable diseases most commonly found in schools are explained to the teachers and they are asked to notify the Health Centre at once of any suspicious case in their school district. All the children are weighed and measured twice during the school year, and those found to be ten per cent. or more underweight are weighed monthly, when special instruction in nutrition is given. After the monthly inspection a class room talk is given on personal hygiene, proper food and drink, etc., covering a routine yearly course of instruction.

Toothbrush and handkerchief drills are held in the primary classes and the teachers co-operate with the nurse in having many entertaining and instructive "Good Health" plays and projects.

Each year the work of the Centre increases; sometimes one phase perhaps more than another is stressed, but the growth is steady, showing without a doubt that the work undertaken is appreciated and of benefit to the public.

Several requests have been received at the National Office for a copy of **A History of Hospitals in Canada**, by Miss M. Louise Meiklejohn (published in about 1908). The Canadian Nurses Association has no copies available. If any reader who has a copy would be willing to dispose of it to one of our University Schools of Nursing, will she kindly notify the Executive Secretary, Canadian Nurses Association, 511 Boyd Building, Winnipeg, Man.?

The Role of the Public Health Nurse

By ELIZABETH G. FOX, Director, Public Health Nursing, American Red Cross

In the last fifty years science has made tremendous strides, as this audience well knows, with respect to our knowledge of the behaviour and treatment of the human body and mind. Scientific experimentation has resulted in great medical and public health discoveries vitally affecting modern medical practice and greatly accelerating the development of preventive medicine. It has often been said that there is sufficient knowledge available today, if it were applied, to bring about a great reduction in morbidity and mortality rates. The problem is to get this knowledge disseminated among the people and applied.

Appealing for a wider diffusion of these discoveries of medical science, Dr. Wm. H. Welch, dean of the School of Hygiene and Public Health, of Johns Hopkins University, a public health authority of world-wide renown, had this to say:

"When a Koch discovers the tubercle bacillus, a Banting discovers insulin for the relief of diabetes, a Von Behring antitoxin for the cure of diphtheria, or a Park demonstrates the value of toxin-antitoxin for the prevention of diphtheria, the world draws a long breath as if saying to itself, 'Now we are rid of that terror which has haunted the human race for centuries.'

"It then straightway forgets and goes on its way comfortably assuming that of course the great discovery or invention is being carried into effect.

"The actual facts are quite different. A few people, those of unusual initiative or ample means, or who happen to be under the care of exceptionally alert physicians, or within the jurisdiction of exceptionally competent health officers, receive the benefits of the new discoveries, but the great mass of the human race goes on as before, and the death rate from these diseases is reduced slowly and over long periods of time.

"In fact, the health field has a woefully ineffective distribution service, as compared with its marvelously effective production service in the laboratories of the world. We know how to do a lot of things which we don't do, or do on a wretchedly small scale. Few of the great discoveries of preventive medicine, except the prevention of yellow fever, are anywhere nearly fully applied."

Dr. Welch and many others have often pointed out that it avails nothing to the people if this priceless knowledge remains locked up in text-books, in laboratories, in the minds of men of science and men of medicine. Not until it becomes the possession and the practice of the man in the work shop, the mother in the home, the teacher in the school, and the child on the playground will it have any noticeable effect upon the health of the people.

The medical profession is seeking to reduce sickness, to prolong life and to promote health. For the accomplishment of this purpose there must be a wider appreciation of the possibilities of modern medicine. Before the doctor can reach his maximum of usefulness and do his best for his patients, the people must realize the value of medical supervision and the wisdom of seeking medical attention on the first ap-

(Read at the Pan-American Red Cross Conference, Washington, 1926.)

pearance of symptoms of physical derangement. Instead of patronizing the corner drug store, patent medicine vendors and quacks, and of seeking advice from neighbours and from promoters of all manner of cults, they must learn to turn directly and immediately to medical men for advice and treatment. Furthermore, it is essential that pregnant women should be trained to seek medical advice much earlier in their pregnancy than is now customary; that mothers should realize the necessity for regular medical supervision of their babies and their children and that they should be guided and assisted in following the instruction of their doctors in the daily care of their children; that there should be a better understanding of prophylactic principles and a greater willingness to submit to such protective measures as vaccination, Schick testing and the giving of toxin-antitoxin, typhoid vaccine and the like; that there should be a clear knowledge of the purpose of quarantine and a livelier social conscience in this regard; that there should be less fear of hospitals and operations.

The medical profession cannot do its utmost either in the fields of cure or prevention until the public is convinced of the soundness of all these measures. But who is going to convince them? There is need of an agent working among the people in their homes teaching the value of modern medicine, advising, stimulating and helping people to have medical attention and building up an ideal of health. The public health nurse is this interpreter, this messenger, this teacher in the home. She has the same goal as the doctor. She, too, is endeavouring to prevent sickness, to delay death and to promote health. To this end she is constantly seeking to have sick people whom she discovers, and people who are in the way to become sick, seek medical advice; patients who may have carcinoma or tuberculosis secure diagnosis and treatment; children who may have a communicable disease brought immediately under observation; pregnant women seek early and regular medical care; babies and young children placed under systematic medical supervision. In all her work she is constantly aiming to get for babies, children and young and old people the benefits of modern medicine.

We conceive of the public health nurse in this country as a family health worker equipped and ready to cope alike with problems of disease and problems of health. We conceive of her as a constructive force for the betterment of individual, family and community health. Her work has three aspects: it is educational, preventive and curative. Of these, the first, foremost and most constant function is that of health education. It has been said that "the distinguishing mark of the new public health is its emphasis on the individual man, woman and child, and their education in habits of hygienic living." It has also been said that "the public health movement of today is pre-eminently a campaign of popular education." While much, or at least some, of this education may be accomplished through group methods: that is, through lectures, exhibits, classes, magazine articles and the like, to achieve a real revolution in the hygienic habits of man requires personal work. It is not a simple task to uproot habits which have become deeply entrenched, especially when they are to be supplanted by other habits which are or seem to be less convenient and comfortable. If I were to ask how many of those in this audience who are familiar with the principles of hygienic living are practising them habitually, I doubt if any one could answer in the affirmative. If it is difficult for us who are supposedly not only intelligent about but constantly preaching health habits to carry them out in our own lives, how

much effort must it require for those who are less interested and less well informed?

Here is the public health nurse's opportunity and responsibility—to explain and to demonstrate to individuals the principles of personal hygiene and to help them apply them in their everyday living in their homes, their schools and their workshops. Coming into intimate contact in home after home with many people, seeing and understanding their personal and family environment, the nurse has a matchless opportunity to make the science of healthful living understandable and interesting. The message which she carries comes from men of medicine and men of science, from physicians, biologists, bacteriologists, hygienists and sanitary engineers. She seeks the help of the psychologist and educator in putting this message into language which will be convincing to the laity. Then she drives it home through the force of her own personality and her service.

Her second function is that of the prevention of disease through early recognition of symptoms, and through persuading men and women to seek medical attention long before they are so ill that they are forced to do so.

Other preventive measures include the supervision of the physical condition of expectant mothers and help in adjusting economic and social circumstances injurious to them; supervision of the health of babies and pre-school children; efforts to have the physical defects of children diagnosed and corrected; to improve the sanitary condition of school buildings and grounds; to find the undiscovered or hidden cases of tuberculosis, scarlet fever and other communicable diseases, and to prevent their spread. These and many other preventive measures are part of her daily work.

In the United States, the third function of the public health nurse is curative—the restoring of the sick to health. We have not yet reached that stage of enlightenment where we are all living hygienically or have succeeded in preventing all needless diseases. The sick we shall always have with us, though let us hope in decreasing numbers. In this country it is estimated that only ten per cent. of the sick are cared for in hospitals; the remaining 90 per cent. are cared for in their homes. Of this 90 per cent., perhaps less than a quarter can afford the services of a private nurse. The majority of them, and this includes people of moderate means, such as professional people and those in small business, must depend upon the services of a public health nurse if they are to have skilled nursing care.

We thus include actual nursing care as a duty of the public health nurse because we are convinced that we cannot successfully divide a family's problems into those of sickness and those of health. There is no possible line of demarcation. The physical condition of the family and all that exists in the home environment to make it what it is must be taken as a whole. Also, the illness of one member has its effect upon the health of the others. In working for the well-being of the family, therefore, we believe that the teaching of health and the preventing of disease go hand-in-hand with the restoring of health to the ill.

Looking at it from a psychological aspect alone, it is thought that the influence of the family health worker is greatly strengthened if she is able to deal with the whole problem. If, when she goes into a home for the purpose of giving advice about some pre-natal, infant or child hygiene problem and finds there someone who is ill, she knows how to give that patient the comfort and the benefit of skilled nursing, her influence over

that family takes on a new and added weight. To be able and willing to help with her own hands when there is sickness and suffering opens the hearts of her people to her. Once she has served them in this way she finds them far more ready to listen to and to take her advice about changing their way of living. Our experience has taught us that there is no approach which gives the public health nurse such an open entry to the homes and hearts of those whom she would serve than that of relieving the suffering of those who are ill.

We have also found that the demonstration to the family of the practice of cleanliness, of sick-room hygiene, of skilled nursing care, does more to convert them almost unconsciously to a more healthful way of living than could mere verbal instruction no matter how tactfully given. The young daughter of the household watches and learns from the nurse in the daily care of a sick mother. The mother who helps the nurse and is instructed by her day by day in the care of a sick child develops a new ideal of personal and household hygiene which has its influence on the health of the whole family and their way of living. He who says that the giving of nursing care has no public health value can never have witnessed the transformation of an entire family brought about by the nurse who uses her nursing as a means of demonstrating and a peg on which to hang her lessons in hygiene.

Let me summarize briefly the activities of public health nurses in the following classifications:

Nursing care of the sick in the home and instruction of the family, known as bedside nursing, and done on the visit basis. Except in emergencies, the nurse does not remain continuously with the patient.

Nursing care of mothers and newborn babies, known as maternity nursing.

Health supervision of babies and small children, including the arrangement of classes in child care and of group conferences with physicians, known as child welfare work.

Health supervision and instruction of school children, assistance to parents in securing the correction of defects and unhealthful habits through visits to the children's homes and supervision of the school environment to eliminate factors harmful to children, known as school nursing.

Nursing care, instruction and supervision of tuberculosis patients and their families and efforts to reduce the spread of infection, known as tuberculosis nursing.

Work for the eradication of communicable diseases, known as communicable disease control.

Health education of the community through lectures, classes, exhibits, movies, parades and clean-up campaigns and other similar devices for catching the public eye and ear in the cause of better personal and public health.

To fulfill these tasks successfully the nurse must be an educated woman, a graduate nurse with special preparation for public health nursing and must possess unusual intelligence and ability to deal with people.

Let me conclude with a quotation from Dr. Winslow, who is thoroughly familiar with the development of public health nursing in this country. He says, "We have sought during the past twenty years for a missionary to carry the message of health into each individual home, and in America we have found this messenger in the public health nurse."

Affiliation

By H. A. FARRIES, M.D., Saint John, N.B.

The fact that the mortality from tuberculosis has been reduced remarkably is due to many causes. One of the chief, however, is education. It is now accepted by a great many authorities on tuberculosis that tuberculosis is a needless disease: but in order to make this a needless disease much educational work must be done. Tuberculosis is really more of a social problem than a medical one. An effort has been made to have the medical colleges give the students an intensive course in tuberculosis work and it has been advocated that students should have two months' residence in a sanatorium for this purpose.

In training schools for nurses only slight attention has been paid to tuberculosis, and to those doing tuberculosis work it is discouraging to find how little the average nurse knows of this disease. An effort is now being made over the whole North American continent to have nurses given a special training in this work. Some states have made it compulsory. All national organizations directly or indirectly interested in tuberculosis recommend that nurses should be given a three months' course in a tuberculosis institution. Some objections have been raised to this, especially by surgeons and the surgically trained nurses, who claim that this training is unnecessary.

In 1925 there were four hundred deaths from tuberculosis in the Province of New Brunswick. The average patient who dies of tuberculosis spends practically the last year in bed. This means that in New Brunswick 146,000 days were spent in bed by the tuberculosis patients in 1925, although many of these patients kept on their feet when they should have been in bed. This gives an average of one day in bed for every third person in New Brunswick.

If, however, the nurses who graduate in this province could be given a training of three months in tuberculosis the morbidity and death-rate would be reduced very quickly. In the opinion of the writer, it is only by arousing the intense interest of medical men and nurses, and by special training in tuberculosis work, that much progress will be made. Then the lay public would very quickly become educated as to this disease.

Some of the reasons why affiliation with a tuberculosis institution will work for the good of all are as follows:

1. It will give the nurses the proper perspective of tuberculosis, which unfortunately is very rarely found today. Nurses will lose the fear of the disease and, incidentally, their parents will also be given a different perspective: and this is a very important point as it is surprising how frequently parents interfere with the nurses doing their duty about nursing tuberculous patients. They will learn that tuberculosis is not a danger to the nurse, unless she is thoroughly incompetent. They will learn, however, to have a wholesome respect for the communicability of this disease and will realize that it is definitely communicable, especially to young children. Unfortunately, in the past—as one man expresses it—we have been too much like the lightning bug and have carried the light on the wrong end, and we do not see tuberculosis until it is too late. One of the greatest proofs of nurses needing education in tuberculosis is that in some of the provinces nurses charge extra for nursing this disease. Only

the lack of proper perspective can allow such a condition to persist.

2. In general hospitals nurses are taught to take care of acute, active diseases, where patients are looked upon more or less as "cases," and there is very little training in handling chronic cases, such as would be given in a nervous hospital, mental hospital or tuberculosis institution. Tuberculous patients are all neurasthenics and each patient must be treated as an individual, and in no institution can a nurse be given a better training in handling the individual person. Tuberculous patients are unusually sensitive and the mental factor in the treatment of tuberculosis is probably 50 per cent. of the treatment. Nurses given a good training in a properly run tuberculosis institution should receive excellent training in handling even acute cases, but especially the nervous case with which they will come in contact in practice. This training in handling chronic cases is very essential.

3. The affiliation of a number of schools with a tuberculosis institution will result in the nurses mixing with the nurses of other schools and a much broader viewpoint will be developed. The teaching in such an institution will be found to be very different from that in general hospitals and should teach nurses to think considerably for themselves and make them much more observant. To teach nurses to think for themselves is a very important matter and need not interfere with the discipline.

4. At present it is very difficult for a small hospital to have an ideal nursing staff, and without affiliation with other hospitals a small hospital is not justified in turning out graduate nurses. But if such hospitals could have their students spend one year, or possibly less, in affiliated institutions, when graduated these students would be competent nurses. Small hospitals are essential and the small hospital must be recognized more and more, and the students of such hospitals by associating with the students from the larger hospitals will receive much education just from the associations. And vice versa with the students from the larger hospitals—as there are two viewpoints which should be known to those from the larger as well as to those from the smaller hospitals.

5. Tuberculosis hospitals and institutions, when they reach a certain size, must have either a training school of their own or affiliation. It is doubtful if tuberculosis institutions should turn out graduate nurses. If such nurses would stick to tuberculosis work alone, unquestionably it would be a splendid thing to have nurses trained for a long period in tuberculosis.

6. Any specialized institution is very likely to fall into a rut and carry on a very self-satisfied existence. Affiliation with general hospitals, and having nurses come in every three months from general hospitals, will very rudely jolt the tuberculosis hospital out of this stage of self-satisfaction; and it is remarkable how such affiliation brings out the faults of specialized institutions and will very quickly raise the standard of that institution.

7. In the affiliated course the nurse is given a splendid viewpoint of public health work. In no class of work is public health more emphasized than it is in tuberculosis work. Attention here must be given to preventive medicine; nose and throat diseases; contagious diseases; venereal diseases, and child welfare will be given a large share of attention. Proper feeding, bathing and clothing also demand much attention. During such a course nurses will be given more or less dispensary work and will see home conditions as they really exist. While to-day there are some nurses doing either preventive

or curative medicine, all nurses should be given some training in preventive medicine before they graduate, and this would encourage the Florence Nightingale spirit.

8. The public have the idea that the rest treatment is used as a cure for tuberculosis. It is not realized by many that the rest treatment is simply an important factor in the treatment of the patient and not of the disease. The value of rest in the treatment of all diseases is recognized by very few persons. It is simply astounding to find the viewpoint of the average person of what is meant by rest, and how to carry on a properly regulated rest in the treatment of tuberculosis, heart disease, kidney disease, or in convalescing from any acute disease, is not fully understood. It is only after an intensive course of association with tuberculosis patients that the value of rest can be fully appreciated; and this rest applies to both the mental and physical. As mentioned previously, the treatment of tuberculosis is 50 per cent. mental.

9. By some it has been considered that tuberculosis institutions are anxious to have affiliation in order to secure nurses at low salaries. This is not true. The experience of the Saint John County Hospital has been that affiliation has actually increased the cost to the institution, as the nurse is paid a salary while taking the course. It requires many more affiliate nurses than it does undergraduate nurses; more charge nurses and a more competent staff. While this is true, nevertheless, affiliation makes a tuberculosis institution more or less of a teaching institution and thus raises the standard very greatly; it also supplies a better grade of nurses than under the old method of employing undergraduate nurses. No longer are nurses in training considered cheap labour for the general hospitals, and each individual hospital should be willing to forego a little individual benefit in order to balance the nurse's training and graduate all-round nurses. It is only by such co-operation that the nursing profession may be raised higher and higher and made increasingly useful.

In such a chronic disease as tuberculosis it has been found very difficult to get the male population properly interested, and it is more on the women that such work will fall —and especially on the nursing profession. I would like to urge enthusiastic co-operation from the nursing profession to eliminate this needless disease—tuberculosis.

Your Summer Holiday—A Trip Abroad?

There is really not one moment to lose in beginning to plan your summer holiday if you want to take a really worth-while one. You can remain in your home city if you wish, or take a short trip, and at the end of your treasured vacation you will have spent as much money as if you had taken a real trip, and you won't have a single new idea.

Last summer a young Canadian nurse from New York took the All-Canadian tour to Europe, and in a letter received from her the other day she said, "I wouldn't part with my memories of that trip or the friends I made on it for anything I can think of. There are a lot of people from here anxious to join the party next summer. I wish I could go again myself." These trips are not confined to one profession, and you will meet people of many minds and from every part of Canada and several places in the United States, and you will come back to your work with renewed zest; with a fresh interest in every book, play and picture, and with memories that will remain with you for life.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss EDITH RAYSIDE, General Hospital, Hamilton, Ont.

Round Table: Problems of Affiliation

In opening the discussion the chairman admitted that the problems of affiliation were many. Affiliations were for varying lengths of time—from three months to one year—making it necessary to repeat lectures and classes in some subjects four times a year to get in the necessary instruction. But as affiliation is necessary for the education and development of the student and has come to stay, a general discussion of the subject would be beneficial and help to clear up some of the difficulties.

In the first paper, by Miss Gertrude Garvin, superintendent of the Isolation Hospital, Ottawa, the subject was discussed from the standpoint of the special hospital. Mention was made of the fluctuating patient population, the large influx of patients during an epidemic, with sometimes long intervals of slackness and very few patients, and the difficulties encountered in meeting such a situation. It was shown that as very young children form a large proportion of the patients constant care and close supervision are necessary, and the importance of a nurse realizing her responsibility as a teacher was stressed.

The second paper, written by Miss Kathleen Panton, superintendent of nurses, Hospital for Sick Children, Toronto, presented the subject from the standpoint of that institution, which provides experience in pediatrics for the students from hospitals where this training is not available. Some of the benefits mentioned were: The establishing of cordial relationships between these schools of nursing; the gaining by the students of a knowledge of new methods of teaching and a broader outlook, and the possibility of students making good in one particular branch of nursing even if not very brilliant in others.

The third paper, written by Miss Catherine Robertson, Alexandra Hospital, Montreal, brought up the point of nurses from so many schools with varying standards of training coming together in one group, and the very short time available in which to give the necessary instruction. Miss Robertson expressed the opinion that matters would be simplified if all students had a knowledge of medical asepsis and operating room technique. Also that bacteriology was essential to clearly follow the course of acute infection.

The replies to the questions contained in the fourth paper give a fairly good summing up:

1. That there is sometimes overlapping of lectures, which might be avoided by better co-operation between the schools; (2) that students should have examinations in all subjects for which affiliation is given; (3) that a record of a student's class work and lectures should be sent with the student to the affiliated school, and record of work standing, etc., be sent with the student on her return to the home school, such records to be accurate but simple; (4) if possible, students should not have to attend lectures and classes in the home school while taking special courses in other schools; (5) that it

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would be advisable to have all serum given during the probationary period in the home school.

M. F. HERSEY, Chairman.

By GERTRUDE GARVIN

I have been called upon to enumerate some of the problems of affiliation, and as my work for the last six years has been in organization and administration of the nursing department in a hospital for contagious diseases, I shall deal more directly and as briefly as possible with such specific problems as have presented themselves to me within this particular hospital.

Affiliation is with us and no doubt has come to stay, unless something better presents itself. We all recognize that it provides advantages and disadvantages to all factors concerned, but the former have evidently predominated or the affiliation movement would not have survived and developed to its present proportions.

To begin, attention is first called to some of the relative problems of the hospital; these, no doubt, being identical with most hospitals of this nature, but which admittedly differ largely from those of the general hospitals, as well as from those of other hospitals that come under the head of "special hospitals."

1. There is the fluctuating patient population.

2. The unexpected and large influx of patients from time to time, due to epidemics, with intervals of slackness, making a situation financially impossible or very difficult to meet by a permanent graduate nursing staff. At times when the need is greatest, graduate nurses are least available from outside, because the seasons for prevailing epidemics seem to be the times of the year when other illnesses prevail to a greater extent—spring and autumn —thereby making larger demands on the nursing supply.

3. A special problem is created also by the fact that very young children constitute by far the larger proportion of the patient population, increasing the need for close observation and supervision.

4. Then there are problems of cross infection, return cases and aggravation of diseases by superadded infection.

5. Conditions due to fluctuating population of nurses, making for instability of standards of nursing procedures and technique.

Affiliation, to meet the need, is a very desirable measure for the hospital, and so far as the nurse herself is concerned, the need of this special training is determined by the demands made upon her at the termination of her training, when she must meet the requirements of registration and comes to the place where she must choose one or the other of the various avenues open to nurses as a professional career, be it private duty, public health, district, school or industrial nursing.

As a part of her equipment for any one of these, this special training is important for the following reasons:

1. It makes the nurse an important factor in the prevention of disease and epidemics and in dissemination of knowledge of hygiene and sanitation.

2. It makes her a valuable aid in the prevention of the occurrence of children's diseases by reason of the instruction she is able to impart to parents or guardians as to the modes of transmission of disease and means of prevention.

3. It furnishes her with the knowledge necessary to combat arguments of anti-vaccinationists and to explain the rationale of immunization to scarlet fever, diphtheria, etc.

4. It broadens her experience by bringing her in contact with students from other schools.

5. It gives to the student, in many cases, her first direct contact with

public health organizations. This is more particularly emphasized when on ambulance service, which brings her into actual touch with the patient's home environment, where she may discover some factors contributory to the patient's disease. The student here has an opportunity of exercising her initiative in simple instructions to the mother as to detection of symptoms in other members of the family who have been in contact with the patient, and in the method of isolation of such till seen by the physician. An opportunity is here given also for brief instructions in hygiene and sanitation.

6. This service tends to broaden the student's viewpoint and brings her to a realization of the nurse's responsibility, and develops to some degree her teaching ability.

7. Again, her experience in the discharge of patients from the hospital brings her once more into personal touch with the parent or guardian, with an additional opportunity for advice as to further care of the patient and the protection of the family.

8. The student also has an opportunity of teaching health habits to the child in the hospital during long convalescent periods, which must have in itself a far-reaching effect.

9. Perhaps one of the points of greatest advantage to the student in the special hospital is the fact that her theoretical instruction and practice are so closely co-ordinated.

The routine of instruction consists of:

1. An outline of the purposes and organization of the hospital.

2. Its problems and the responsibility of the nurse in their solution.

3. A brief outline of the Federal, Provincial and Local Health Departments, Local Health Agencies and Public Health, School and Industrial Nurses, Tuberculosis, Venereal Diseases, Pre-natal and Baby Clinics, Provincial Laboratory—one excursion to each, when possible.

4. Lectures, clinics and class instruction in the care of all communicable diseases, general principles and medical asepsis.

5. Epidemiology, immunology, Schick and Dick tests, convalescent serum.

6. Care of communicable diseases in the private home.

I may say that in the absence of university and other medical centres of instruction, no other influence could afford greater stimulus than the coming to our hospital of groups of eager, interested young women, most of whom are keen on getting the best we have to offer.

While affiliation affords to the hospital and student nurse the advantages already mentioned, there are several incidental disadvantages to both the hospital and student under existing arrangements:

1. There is the constant coming and going of a large proportion of the nursing staff, which makes for a restless, unsettled atmosphere, and an instability of the whole service.

2. Confusion due to conflicting methods and technique in "nursing procedures."

3. Greater extravagance in the use of supplies.

4. Greater carelessness in regard to hospital equipment.

5. A tendency on the part of the student to relax in ethical standards, uniform and discipline.

6. An apparent inclination to freedom and independence on the part of some students.

7. Many students lonely and unsettled for a week or two and fearful of contracting communicable diseases.

8. Students not all of the same clinical experience or instruction and coming from schools whose educational requirements differ.

9. Officers of the special school are limited in their opportunity of close acquaintance with the personality of

the student, contact being so brief as to afford them little chance of learning her special abilities, qualifications or faults.

10. Last, but not least, of these adverse features is the interruption of the student's clinical training by the necessity of returning to her parent school for classes, lectures and examinations, so that her interests are divided and her time for necessary rest and recreation limited. As classes and lectures are carried on at the time when the service is heaviest, the result is many loose ends in the nurses' work, and difficulty in providing adequate care for patients during the absence of a large proportion of the nursing staff for periods of two to four hours three or four days a week.

In the mind of the student nurse the inference is likely to be that greater emphasis is placed on theoretical instruction than on the care and welfare of the patient.

Again, the student is likely to infer that, while for some reasons the training in the special hospital is necessary and desirable, it in no degree compensates the student for her absence from the parent school.

By KATHLEEN PANTON

The purpose of affiliation is to provide for the student experience which is not available in her own hospital.

The benefits: (1) It establishes a cordial relationship between training schools and hospitals; (2) it gives the student an idea of comparative training for a common profession; (3) it brings the student into contact with new methods of nursing, thus widening her range of knowledge; (4) psychologically it lifts her from the intense concentration of three years' study in one working atmosphere.

The training of affiliated nurses means to every superintendent a vast responsibility, therefore there are many things to be taken into consideration.

The problems: (1) The student should affiliate with the idea of taking kindly to her new surroundings, and without question she should render cheerful and prompt obedience. If, on the contrary, she is prejudiced and continually makes comparisons, her experience will be a matter of lost time.

(2) Attitude towards correction of student: In the parent school the officials are aware of her shortcomings and of her good qualities, but in the affiliation school she has again to win her spurs. In view of this the necessity for an open mind on the part of all concerned is strongly emphasized. To gain the confidence of the student leads to mutual trust, which reveals its own reward. Here one is reminded of the old saying, "As she behaves, the credit or the blame reflects upon the parent," in this case the parent school.

(3) Regard for hospital equipment: The fact that it is not her own school does not warrant a student being careless or wasteful with articles entrusted to her care. Pride in her work will inspire trust and confidence and win a valued reputation.

(4) Special discipline—which unfortunately is sometimes necessary—should be determined by the two superintendents concerned, but acted upon by the superintendent of the parent school.

May I for a moment direct your attention to the affiliation course which is followed in the Hospital for Sick Children, Toronto?

In addition to the training of our own pupils we accept and train approximately 150 affiliated students yearly.

As all affiliated students spend one month on the Infants' Ward I shall outline the programme for that department.

The accommodation is for 65-70 patients; staff:—4 graduates, 3 in-

ternes, 1 nurse to every 2½ babies. Instruction is provided for the students through the following: (1) their routine practical nursing; (2) rounds made daily by the staff members; (3) bedside teaching by the internes; (4) demonstrations by a graduate, who is there for the sole purpose of teaching.

Instruction in the preparation of milk feedings is given by the dietitian in charge of the milk laboratory, which embraces four lectures and six demonstrations in practical laboratory work. This offers ample opportunity for every student to become familiar with the making of milk feedings.

Terms of acceptance: (1) To sleep in their respective residences; (2) to report for duty at 7 a.m. or 7.30 a.m.; (3) to have had their experience in obstetrical nursing; (4) in the event of illness to be cared for in their own hospital; (5) when off duty to have the use of rest rooms allotted to them in the nurses' residence.

Final reports are sent to the parent schools as requested. These outline: time of service spent in the various departments, hours of instruction, laboratory work, special lectures, time off duty through illness, time made up, report of student's standing, and are signed by the superintendent.

It is realized that the affiliated nurses have come for instruction and experience and every endeavour is made to render the time spent profitable to them.

By CATHERINE ROBERTSON

In the curriculum for a three years' course in recognized schools of nursing so many branches of the profession are included that many hospitals have had to arrange affiliations to give the student nurse the necessary experience—small training schools and special hospitals affiliating with the large schools for medical and surgical work, while many large hospitals, having no departments for maternity, communicable diseases and pediatrics, send pupils to a special hospital giving a short course in these subjects.

This article is written from the standpoint of the special hospital giving such a course to pupils from a number of general hospitals of varying size and with probably varying standards of training. This last remark is in itself sufficient to start a discussion of the difficulties of this work, including the administration of the hospital and the teaching of the subject.

There is the arranging of a continuously changing staff. Attempts made to have groups of pupils enter at regular intervals have not proved successful. Time lost through illness or any other cause must be made up, and a certain number always fall behind, disorganizing the assignment of ward work and the class-room group.

Good co-operation between hospitals is very necessary to minimize this difficulty. The number of pupils from any hospital should be guaranteed and when a pupil has to give up the course before completion she should be replaced at once.

From time to time the question has come up: should the hospital giving an affiliation be supplied with the pupil's record? There seems to be two sides of this question to be considered; on one hand it might possibly assist the administration, in that nurses would be arranged according to merit, an inferior nurse being capable of upsetting the most carefully detailed schedule. But is this quite fair to the pupil? Individuals react to inclination and interest; it might be possible that a special subject making those appeals would give exceptional results judged with an unbiased opinion.

If definitely stated, another point which would help both in the administration and teaching, would be that pupils have experience in sub-

jects both in practice and theory correlating with the special course. For example, in the handling of communicable diseases operating room experience makes the technique of medical asepsis more easily understood, and bacteriology is essential to clearly follow the course of any acute infection.

Great difficulty has been experienced in trying to arrange the instruction of special courses; a haphazard collecting of knowledge will no longer suffice when the subject forms part of a three years' training. Theory and practice should be combined in a planned curriculum with time and content stated.

When the course given covers the short period of two to three months, repetition of the theoretical work has seemed inevitable if given concurrently with the practical training in the special hospital.

And what of the nurse who from lack of time or because the course is optional does not take the practical training? Some knowledge of the subject can be acquired through lectures. A solution of the last two points made seems to be the centralizing of instruction.

To give an instance of how this can be arranged: Last autumn the hospital I represent suggested that the instruction in communicable diseases be centralized, the course to be given by the consulting physician and the instructress of nurses from the special hospital handling these diseases, and all the recognized training schools in Montreal agreed to send pupils to the University for lectures. Sixteen hours' instruction covered a period of two months; weekly evening lectures, eight in number, were given by the doctor, each lecture followed by a separate afternoon class taking the form of a quiz and details of nursing care by the instructress of nurses. To make the groups of manageable size it was found necessary to give three courses: the first in October and November, the second in January and February, and the third in April and May. In all 202 nurses attended, and of those 100 have, up to date, taken the two months' practical work completing the course, and 24 hours' instruction.

Hospital Walls

By Gloria Goddard

White?
Look close—
Their smooth flat surfaces,
Like the sensitive wax of recording discs,
Bear immortal history.
The unseen script of living
Is traced upon these walls.
Invisible legends of life and death,
Etched indelibly.
The pale thin wail of the new-born babe
Sketched lightly—in that corner, there;
Yonder, in fading lines,
The sigh of a last farewell;
Close beside, almost splitting the plaster,
An agonized scream of pain;
A pæan of joy for a dear life saved,
Drawn with flourish of hope on the ceiling;
And in between, and all round,
Faint sighs scrawl,
Deep moans smudge,
Hot tears blur,
Sad hopes falter,
Like a hand unschooled to write.
White walls?
Look close——.

Department of Private Duty Nursing

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Pre-Operative and Post-Operative Principles

By R. V. B. SHIER, M.B. (Toronto), F.A.C.S., Toronto

A very great honour was conferred upon me when requested by the Academy of Medicine of Toronto to appear as its representative before this splendid organization. It is indeed a privilege to bring to this convention the best wishes of the Academy.

The title of this paper is one which concerns nurse and doctor alike. It is one phase of our work in the healing of mankind where co-operation is most essential, and where it is important that the nurse in charge should understand the why and the wherefore of the measures adopted in each particular case. In the past there has been too little pre-operative preparation, because very often those in charge lost sight of the fact that it takes a great deal more than a surgical operation to cure the majority of patients. In the future surgery must cease, more and more, to be merely a technical problem, and surgeons of the present and future, in order to improve the immediate operative mortality, the percentage of cures, and the degree of economic efficiency, first must be physicians, and be fully aware of the biochemical processes at work in the living organism. And not only are we as a Nursing and Medical Profession realizing the importance of adequate preparation, but the public are becoming alive to the fact. It is particularly annoying to read in the daily press that so-and-so died as a result of, or following an operation. This as we know is absurd in the great majority of cases, and the time is long past when we should attempt to prove to the public that patients as a rule die of their disease, and that any surgical procedure undertaken was the best for combating that disease.

There has been, we are glad to say, a rapidly growing tendency toward the unity of all departments of medicine, but possibly no single branch has influenced and will continue to influence surgical results as has the study of biochemistry. This is exactly as it should be, for we poor humans are simply a compound of fats, sugars, proteins, inorganic salts and water, while our waste products are largely carbon compounds, the result of metabolism. Therefore the application of biochemistry in solving some of our pre-operative and post-operative problems is only logical.

Outside of surgical emergencies, such as acute appendicitis and traumatic conditions, the majority of patients will be found to be chronic invalids, suffering from one or more of the following: first, toxaemia; second, anaemia, and third dehydration. The toxaemia referred to is that existing for a long period of time, and may be of many different types. The patient with a chronic focus of infection has a saturation of bacterial toxins. The patient with toxic goitre has had excessive quantities of thyroxin, usually of abnormal chemical composition, circulating in his blood stream, often for a number of years. The diabetic has an acidosis, the result of Nature's efforts to manufacture a false sugar (acetone), from fat, all because the warehousing function of the liver for sugar is out of commission. The toxic products in these cases are diacetic

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and beta-oxybutyric acids. The patient with jaundice may have an acidosis because of disturbed liver function, due to a definite lesion in the liver tissue. On the other hand, in cases of intestinal obstruction, in addition to histamine poisoning, we have a definite alkalosis. The degree of alkalosis increases in intensity the nearer the obstruction is to the duodenum, the blood chemistry being so altered that we have increased carbon dioxide combining power, increase in non-protein nitrogen, and decrease in blood chlorides, and finally we have the patient with altered kidney function, resulting in uraemia, as seen in prostatic obstruction or bilateral kidney stone, or other kidney lesions interfering with the normal excretion of urine.

As a result of these various poisons, or other blood-destroying agents, we have varying grades of secondary anaemia, and the effects of these various poisonings are augmented by lack of fluid intake, the result being what we call dehydration. This lack of fluid is certainly not conducive to health.

Now what have we at our command to help re-establish anything like normal balance in these patients, thus making them as safe as can be for surgical operations? The first, and most important, is water, and the only indication for limiting the intake of water is oedema. If oedema is absent, the supply of fluid given should not be less than three thousand c.c.'s per twenty-four hours, and may be much more in badly dehydrated patients. The fluids referred to are water, saline solution, glucose solution, and milk or other fluid nutriment, and are given by mouth, interstitially, or intravenously. Other measures adopted are suited to the case in hand. The patient with acidosis must receive glucose freely. Glucose is a monosaccharide, and supplies a readily handled food. If acidosis is present the need for acetone is dispensed with when glucose is supplied. The patient with alkalosis can be redeemed from his toxaemia by giving sodium chloride solution interstitially or intravenously, the amount necessary being determined by daily blood chemistry study. Ammonium chloride per rectum is a quick method of raising blood chloride. Under no circumstances should a patient with alkalosis receive sodium bicarbonate or other alkali; and just here let me say that the common practice of nurses giving soda to a vomiting patient is a most dangerous one until the blood chemistry has been determined. The thyro-toxic patient, in addition to fluids and rest, receives iodine to enable the thyroid gland to manufacture a normal thyroxin, while the jaundiced patient is given calcium chloride intravenously once daily for three days, to hasten the clotting time of the blood, which as we know is delayed in the presence of jaundice.

The foregoing remarks deal with the management of toxaemia, which as you see is largely corrected by overcoming dehydration, or by elimination, by giving sufficient fluid. There remains the question of secondary anaemia, and our most efficient means of correcting this is by blood transfusion, especially if there is the question of urgency. Dietetic measures and medicinal remedies will help correct the blood dyscrasia, but are more time-consuming.

To recapitulate: we have water, glucose, salt solution and blood transfusion, any one or all of which may be necessary, to be used judiciously for a week or ten days, to convert a doubtful risk into one of safety. Patients commonly think this quite a long period, but when it is pointed out to them that such preparation makes for safety and a shortened convalescence, they readily fall in line.

All that has been said regarding pre-operative preparation applies with equal force in post-operative

care. But we will approach the subject in a slightly different manner, and deal specifically, for the sake of emphasis, with certain outstanding problems as they affect the nursing. For the first three days at least, the average patient who has had an operation of any magnitude, should receive at least three thousand c.c.'s of fluid. This may be administered by mouth, interstitially or intravenously, as already pointed out. Our practice of late has been to commence an interstitial of saline immediately on the patient's return to bed. About 1000 to 1200 c.c.'s are given over a period of two hours or more, when the flow is discontinued, to be re-commenced some three or four hours later, leaving the needles in place in the interval. This method is no better than any other which avoids undue distention of the tissues over a long period of time. Needles should always be inserted through a wheal of novocaine or local anaesthetic, and should point backwards toward the axillae. At the same time water is given freely by mouth. Intravenous administration of saline or glucose is reserved until definitely indicated. We have given up the rectal administration of fluid—the so-called Murphy Drip—on account of the uncertainty of the quantity of fluid absorbed, and the annoyance it causes both patient and nurse in the majority of cases.

The next point to be considered is the control of pain. The question of how much and how often morphia alone, or combined with atropin, should be given, can be answered in only one way—a sufficiency to keep the patient absolutely comfortable mentally and physically. In abdominal cases the quantity of sedative required is reduced by the application of a linseed poultice. The great point during the early period of convalescence, is freedom from pain. Post-operative pain comes from two main sources: first, the wound, particularly the parietal peritoneum; and second, distention—the first, on the first day, and both for a few days following. Painful wounds are avoided by gentle manipulation on the part of the surgeon, and by avoiding unduly tight suturing: for approximation, and not strangulation, should be the aim of wound closure. The causation of post-operative distention is a problem concerning which certain factors are known. Blood chemistry studies tell us that the blood must contain .4 of chlorides before peristalsis can take place, or in other words there is no intestinal movement if the blood chlorides fall below that point. A temporary paresis frequently exists for the first twenty-four to thirty-six hours after an abdominal operation. This quickly recovers, or does not occur at all, if the exhaustion has been efficiently treated before operation. One frequently hears the term paralytic ileus applied to a persistent distention, even up to the point where bowel contents are vomited. I am convinced that true paralytic ileus is a very rare occurrence if it occurs at all, and that any intestinal distention persisting or commencing after the first thirty-six hours is intestinal obstruction of mechanical origin, or the result of a localized or general peritonitis. However, it is with the early, temporary paresis causing distention that the professional nurse is particularly concerned: and just here let me point out that she must be sure that the patient really has sufficient distention to cause pain, for patients with wound pain frequently hold their abdominal muscles so rigid that they mimic distention very closely. Granted that true, gaseous distention exists, the most efficient means of exciting intestinal peristalsis, provided the chloride content of the blood is normal, is by pituitrin ½ c.c. and eserine, grains 1-50, given together, thereby increasing their value six times. An enema may be given to hasten relief, but by all means avoid useless and unnecessary

enemas in the first thirty-six hours of convalescence.

Post-operative nausea and vomiting ceases to be a very great factor if the foregoing principles are recognized. Vomiting when it occurs may be classified as toxic, obstructive and neurotic. We have already dealt with the question of toxaemia, and have outlined the means of preventing or treating it. When intestinal peristalsis has been established, either by chemical or surgical measures, the vomiting due to obstruction is relieved. There are some people who have an idiosyncracy to morphine, and are made to vomit by its use. This must be borne in mind, but it is not of such frequent occurrence as to alter the principle of its general use for pain. Occasionally the vomiting seems to be of a purely neurotic nature. A few years ago I made the statement that any vomiting not the result of intestinal obstruction, which persisted past the third day, was likely to be of neurotic origin. With increasing knowledge, and a proper conception of a biochemical basis for a good deal of our post-operative worries, the cases of neurotic vomiting have grown fewer in number. Nevertheless the fact remains that some causes of persistent vomiting of clear fluid are readily cured by a good dose of bromide per rectum or the application of a stomach tube.

Sleeplessness may be treated by various means. The first question to the sleepless patient should be "What keeps you awake?" If it is the bed, change it from Gatch frame to straight mattress. Let all patients change their position frequently. If it is pain, combat the pain. If it is a state of mind, which it commonly is later on in convalescence, one must convince the patient that he can be made to sleep.

In dealing with the physical difficulties of patients, the existence of a strong mental factor in many must not be forgotten. If all people were endowed equally with mental equilibrium there would be no reason why one uncomplicated case should have a convalescence different from another. But nurses and doctors know that patients vary a very great deal. It is of little use to say, "Oh, he or she imagines this or that," and expect that time will effect a cure. Imagination is a disease, and a very difficult one to treat. The old adage that an ounce of prevention is worth a pound of cure never was more applicable than here. Make the patient co-operate in the recovery. If the wound is infected; if phlebitis develops, or any other complication arises, he should be made to realize that some responsibility should be shared by himself and his tissues, for a lowered resistance to infection may have been there, and is undoubtedly there in a number of cases prior to operation. We are not responsible for the disease, but are concerned chiefly in piloting the patient safely through to complete recovery, or in making the passage from this world to the next, easier for him. Too many patients adopt the attitude that they are martyrs to science. About the worst thing for a nurse to do in the case of the imaginative patient, or indeed of any other, is to follow, chart in hand, the physician or surgeon outside the closed door, or to point out, in the presence of the patient, certain facts already noted on the chart. These are both useless performances, and only serve to breed suspicion on the part of the patient. For being open, honest and above-board, we are rewarded with confidence, and imagination is choked out.

As we realize more and more that science is necessary in the principles of pre-operative and post-operative control, so soon will our results improve in depth of gratitude from our patients, as well as in reduction of the operative risk in those suffering from diseases requiring surgical measures.

Department of Public Health Nursing

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Midwifery in England

By MARY BEARD, Advisor in Nursing, Rockefeller Foundation

[Editor's Note:—Miss Beard spent seven months during 1924-1925 making a study of maternal care in England especially as it pertains to nurses and midwives. She made brief visits to seven European countries and spent a longer time in Denmark in order that she might compare their experience with midwives with that of England.]

Long, long ago, between 1578 and 1655, there lived in England a wise doctor who was concerned about the kind of care English mothers received when their babies were born. His name was Dr. Percivall Willughby. He was the intimate friend of the great William Harvey, and this is what he wrote of the duties of a midwife:

> The midwife's duty, in a natural birth, is no more than to attend and wait on Nature, and to receive the child and (if need require) to help fetch the after-birth, and her best care will be to see that the woman and child be fittingly and decently ordered with necessary conveniences, and let midwives know that they be Nature's servants. Let them always remember that gentle proceedings (with moderate warm keeping, and having their endeavours dulcified with sweet words) will best ease and soonest deliver their laboring woman.

More than 35 years ago English nurses and others began to work through the Midwife's Institute for the "efficiency, comfort, and development of midwives," and to petition Parliament for their recognition. Believing that the care of mothers in a normal child-birth was a neglected branch of nursing, those fine pioneer spirits set about the task of enlarging the recognized duties of an English nurse to embrace those of a midwife also.

The Central Midwives Board is a representative English body, open-minded, fair, kind and expressing in an unusual degree the finest ideals of midwives. Listening to the proceedings of the penal sessions of the Central Midwives Board, I thought of many devoted sessions similar to these, through which many of the very members present that day have sat patiently working out the standards necessary to raise the life of a midwife to an economic level where proper compensation for reasonable hours and conditions of work will be attained. With the picture of these penal sessions in my mind is another vivid and unforgotten scene. A midwife took me with her to a delivery in a London home. The technique of the delivery was beautiful, but it is not that which is so unforgettable—it is what we must call the psychology of a midwife that made me long to have certified midwives for the mothers of my own country. From the moment of the midwife's arrival in that small attic room a quiet assurance seemed to descend upon the patient and to give her courage, control and endurance such as she had not had before. To me, midwives, such as composed the membership of the Midwives Institute, seem to be nurses, for though some have not had all the training necessary for general nursing, all midwives have a thorough knowledge of a very special branch of nursing.

I have found in many European countries the same expressed ideal as in England—that education in nursing, in social work, in the laws of public health, should all be part of the midwife's training for her work. Everywhere I have found a tendency

to increase the length of training. In Denmark they hope soon to make the course two years instead of one, and to add nothing to its content, only give more time to learn more thoroughly the subjects already included in the curriculum.

Without attending penal sessions of the Central Midwives Board one could not realize fully how much English midwives, organized for the protection of their highest ideals, have done to safeguard the care of mothers in England. At the two sessions attended, I had an opportunity to observe the fairminded and understanding consideration of midwives shown by the Central Midwives Board. Five midwives were present and, in addition, one doctor to represent the Midwives Institute. At its very best, and that best is inspiring, the life of a midwife is difficult, and some of the stories I heard at those sessions show the midwife's life under very difficult conditions indeed.

It cannot be easy to pass judgment at the Central Midwives Board, and yet I felt that the highest traditions of medicine and of nursing were guiding the members, for the mother and her well-being were the first consideration, and afterwards the most considerate care and patient forbearance of the midwife under criticism. The goal every member of the Central Midwives Board sought was to help her back to a position where she could maintain the standards set for her calling, but if, for the sake of the mothers, it seemed to the Board that after many trials she could not meet those standards, her name was stricken from the list in such a way as to leave no bitter sense of injustice in her mind. The organization of the Central Midwives Board seemed to me so democratic that with midwife representation for the large group in the Midwives Institute and also in the Queen Victoria Jubilee Institute the decisions of the Board must always be very largely influenced by the opinion of midwives themselves.

Maternal Mortality

In the United States and Canada the maternal mortality rate is 6 and a fraction per 1,000 births.

In England it is 3 and a fraction per 1,000 births.

Midwives in the United States are not generally recognized, and although a conservative estimate gives 50 000 women practising midwifery they are not, except in a few states, subjected to centralized training, control, or any sort of standardized procedure. In Canada it is maintained that such women **do not exist**.

It is a fact worth recording that the rate of maternal mortality is practically the same in the two countries; this seems to show that the unsupervised midwife in the United States is not wholly responsible for our death rate.

The recognition of public responsibility for the care of mothers in childbirth has been long in coming to the western continent. The medical profession both in Canada and in the United States has been loath to introduce the Old World midwife as a necessary part of the system of preventive or curative medicine in the New World. The nurses of America have been reluctant to share their work with partly trained women who would be responsible not only for delivery, but also for the nursing care of confinement cases.

We usually determine our public health programme by considering its bearing upon the general welfare of the community. This we decide by studying mortality rates and resulting economic loss to the community and the country at large. Our rate of maternal mortality is high and the resulting economic loss great, and it seems evident that we are far behind in our arrangements for the care of American mothers in child-birth, simply because, both in the United States and in Canada, we refuse to consider maternal care an essential,

indeed a foremost, concern of the public health authorities.

Comparing Care in England and the United States

The striking points of difference between our country and England seem to be the following:

First—In England and Wales the matter has become a primary concern for the public health authorities and thereby has been, to a great extent, taken out of the field of curative medicine.

Second—The money expended by the Ministry of Health in England and Wales on maternal care for the years 1922 and 1923 was £1,725,263, or something over $8,500,000.

Third—In England and Wales midwives are attending, on the average, between 55 per cent and 60 per cent of all births and are subjected to central governmental control and obliged to call a doctor for abnormal cases. (In some parts of the country as many as 90 per cent of all births are attended by midwives.)

England provides for care at confinement by recognizing a group of women whose function it is to attend normal births, **calling in doctors** when abnormalities occur. Training, inspection, and control of these midwives is in the hands of a Central Midwives Board organized in such a way that all the several groups of persons concerned (i.e., Medical Profession, Ministry of Health, the Local Supervising Health Authority, Queen Victoria's Jubilee Institute of Nurses, Midwives Institute and others) are represented upon it. The local administration of the Midwives Act is entirely dependent on the energy and efficiency of the County Councils and County Boroughs, and varies greatly. A member of the Central Midwives Board tells me that in some of the rural counties the spirit of the Act is, even yet, scarcely operative. The £1,725,263 referred to comes from the Ministry of Health in the form of unsupervised cash payments for maternity benefit under the Health Insurance Act; from taxes paid through the local authorities for the purpose of maternal care. These last grants aim at providing a service, not at making individual payments.

Such a programme presents three distinct educational problems—

The education, the training and the experience necessary for: medical students, nurses, midwives.

Even a superficial comparison of the requirements for the training of a nurse or a midwife and the requirements for educating a medical student makes clear the difficulties of the present position. A midwife must, before getting her certificate, have attended not less than twenty births, while it is difficult to secure an equal clinical experience for a medical student, and in some good medical schools he does not personally attend more than **six or seven.** That the doctors who are expert consultants for these midwives should have so slight a training in normal child-birth is an absurdity apparent both to the midwife and to the doctor. Nor does the previous medical education of the student take the place of clinical experience. "Twenty personal deliveries," says Dr. Janet Campbell,* "are none too many to qualify a practitioner in this branch of medicine, even if the most is made of each case." If, as a leader in the Lancet, May 7, 1921, points out, it is really the part of wisdom to "leave the midwifery bag at home and keep your hands in your pockets" then it is deplorable that the vast majority of doctors do not do so but so frequently use forceps. In 78 out of 100 cases attended by general practitioners in a certain hospital, as shown in a recent comparison, forceps were used, whereas forceps were used in only four cases out of the "control" 100 under care of the hospital staff.** Although it seems clear to an observer that the mothers of England are much better cared for in child-birth than are the mothers in the United States, yet Sir George Newman, in an introduction to Dame Janet Campbell's Study of Maternal Mortality, 1924, makes the following

*See Ministry of Health Publication, Physical and Medical Subjects, No. 15, 1923.

**This was not in England.

statements of the position of England in this matter:

Maternal mortality is relatively excessive in England and Wales.

Since 1902 maternal mortality has not declined proportionately in the same degree as the death rates from all causes of women at reproductive ages, as the general death rate of all persons of all ages, or as the infant mortality rate for children under one year of age. In fact, the child-bearing mother is not sharing equally with the rest of the population in the improved public health.

Maternal deaths are due principally to sepsis (puerperal infection) and to other complications of pregnancy, but deaths due to the former have shown a greater decline since 1902 than those due to the latter cause.

The risks to women in their first confinement are certainly greater than in most subsequent confinements.

The decline in the birth rate, which obviously may bring about a general change in the constitution of the people, has exerted a relatively small effect upon the degree of maternal mortality.

In respect of the proportion of maternal mortality England and Wales compare unfavourably with Germany, Norway, Italy, Sweden and Holland.

Excessive rates of maternal mortality are found in the aggregate in the most rural areas and in highly industrial areas (engaged in textile manufactures and coal mining), and especially in certain county boroughs.

Use of Term Midwifery

The word midwifery, in England, is used commonly and in a connection never heard in the United States. For instance, a doctor practises "midwifery" or a medical student "takes his midwifery."

"Midwife" seems to us on this side of the Atlantic almost obsolete. It never was a good word, meaning in its most popular days nothing more significant than "**with the woman.**" It would seem wise to find another English phrase to express what is meant by a well-educated, professional woman who is an attendant at normal child-birth.

In France the **sage-femme** or "wise-woman" has real dignity of meaning, and in Denmark their **jordemoder** or "earth-mother" has at least the historic significance attached to the Roman father who pronounced the life or death sentence on the baby raised up from earth by the attendant. A **maternity nurse** who has become a skilled accoucheuse conveys to us the person whose work is the subject of this study. It seems an unnecessary handicap to make use of the word "midwife" at all. She is to be found with all varieties of social equipment —from one recently stricken from the roll in England because she was too ignorant to learn to read a clinical thermometer, to the Danish **jordemoder** who went to court balls while she was being educated in the State School for Midwives—her sister being a lady-in-waiting at court at the time.

In theory a high standard is universally set for her. Professor Couvelaire, of the Faculty of Medicine in Paris, Dr. J. S. Fairbairn, St. Thomas's, London, Professor Hauch of Copenhagen University, all agree that an educated woman is best for this work and that she requires knowledge of nursing and of social and public health methods as well as a very exacting training in the theory and practice of the care of the parturient woman. Florence Nightingale says:

Between midwifery and all other hospital nursing there is this distinction, viz., the operator is herself the nurse and the head operator or midwife ought to be a woman.

Status of the Midwife

At its best the life of a person, whether man or woman, doctor or midwife, who attends labor cases, is a very exacting one. At its worst, it becomes so difficult that the superior type of woman described above cannot continue in it. The chief obstacle to establishing such an order of obstetrical assistants in England lies in the economic and social position they occupy. When we remember that it is only 20 years since the Act was passed, and that there are over 50,000 midwives on the roll, of whom only 16,000 have notified their intention to practise, the economic diffi-

culties become evident. Salaries have been, and still are, pitifully low. Social standing in the community may be measured by the fact that it is unusual for one who can afford a doctor to employ a midwife in England, even though it is theoretically conceded that a midwife is better at normal births than is a doctor. The psychology of having a woman who is trained to wait patiently, to let things take their course without interference, to sustain the mother with the sense of that unhurried normal outcome goes far to produce the desired result, just as a good nurse does something in the care of a patient with pneumonia that a doctor cannot do. Public opinion on this point has still to be formed in England.

One often hears English people say that ideally, a doctor and a midwife ought to be engaged for every mother. The midwife will then call the doctor if she needs him or the patient wants him.

Work of the Queen's Institute

In order to understand the work of the nurse-midwife in rural counties of England, it is necessary to describe briefly the organization of the Queen's Institute.

District nursing in England is administered through a central national organization having headquarters in London, and known as Queen Victoria's Jubilee Institute for Nurses. Endowed by the Queen and others, there is an annual income of about 5,000 pounds, while the difference between that and the annual expenditure of about 16,000 pounds is made up from patients' fees, voluntary subscriptions and the like. The work of the Queen's Institute falls into three divisions—training, inspection, and organization of district nurses. Fully-trained hospital nurses are taught to be district nurses, and many of these are also taught midwifery. The district training covers a period of six months, and is given in one of eighty-three affiliated "Homes" of the Institute. On satisfactory completion of training the nurse is enrolled as a Queen's Nurse and goes to work under a nursing association affiliated with the Queen's Institute. Systematic inspection of district nurses is an essential factor of the work of the Queen's Institute—it is carried out by inspectors from among the Queen's Nurses. Reports of these inspections are submitted to the Committee of the Queen's Institute and the result communicated to the nursing associations, which raise money for local activities and function as does a visiting nurse association in the United States.

In many country districts there is neither work nor money to justify the engagement of a Queen's Nurse, yet there is a great want of care for ordinary ailments and chronic cases and above all, there is a great lack of midwives and maternity nurses. A special class of nurses, called village nurse-midwives, who have not had full hospital training, but have had training in district nursing and midwifery, is provided for these areas. County nursing associations in affiliation with the Queen's Institute train and supervise these nurses and organize and affiliate local nursing associations.

In addition to securing a high standard of training and work, the Queen's Institute acts as an advisory and executive centre for the nursing associations in the general organization of the work, in negotiations with government departments, and for national schemes, such as the arrangements with approved societies for payment for the nursing of their members.*

The Midwives Act of 1902 found already organized in the Queen Victoria Jubilee Institute for Nurses a vehicle for its efficient enforcement throughout the country. Not infrequently one hears regret expressed

*Taken from the Queen Victoria's Jubilee Institute for Nurses Thirty-second Annual Report, 1923.

that the Queen's Institute has never been made the official instrument of the Act. Such a procedure would seem to have certain advantages, although one can also see that a voluntary organization such as this is in some respects better as an auxiliary to the local supervising health authority. However that may be, the results obtained by the Queen's Nurses and village nurse-midwives leave very little to be desired.

The English Midwife

Who are the midwives of England? What has been their educational and social background? How and where have they received their technical training? Is there provision for post-graduate work so that, as time goes on, they will not fall into careless ways of working? Is their economic status such as to enable them to earn and save enough so that they may spend the best years of their working life in their calling?

The English midwives are not all alike. There are still some of the "bona fida" midwives who were practising when the Midwives Act went into effect in 1902. They had little education and, inevitably, they have been and still are the most difficult problem of the Central Midwives Board. Then there are graduate nurses who take their Central Midwives Board examination in order that they may complete their preparation for nursing but without intending to practise midwifery. There are also

1. Nurse-midwives in practice.
2. Non-nurse midwives trained after the Act.

There is no one central midwife school as in Denmark, nor is it made financially possible, as in Denmark, for every English midwife to return in order to take a post-graduate course. There is no system of pensions for English midwives.

The Central Midwives Board must approve every training centre for midwife instruction, and these are connected with hospitals and out-patient services in many centres throughout England. In 1925 the required time for the training of a midwife (not a nurse) was extended from six to twelve months and for a nurse from four to six months.

The following report is given in full inasmuch as it covers widely-separated areas and all varieties of urban and rural living conditions in England and Wales:

QUEEN VICTORIA'S JUBILEE INSTITUTE FOR NURSES

Report of the Work of Certified Midwives under the supervision of the Q.V.J.I. for the year 1923

45 Inspectors and Superintendents in England and Wales have furnished reports from:

373 Queen's Nurse-Midwives (an increase of 155 on 1920, the date of the previous report).

2,164 Village Nurse-Midwives (an increase of 224 on 1920).

78,072 cases were attended as midwife or maternity nurse (an increase of 4,261 on 1920).

Attended as midwives, 54,554 cases (an increase of 5,474).

Maternal Deaths

81 including deaths from all causes: 14 per cent or 1.4 per thousand (1920, 1.8 per thousand).

Causes of Maternal Deaths

15 Hemorrhage.
10 Sepsis.
10 Embolism.
10 Placental difficulties.
4 Complications.
24 Complicated with other diseases. (Full details given in uncondensed report).
8 Eclampsia.

Infant Deaths

750 or 1.37 per cent (1920, 1.10 per cent).

Stillbirths

1,678 or 3.3 per cent (1920, 2.6 per cent).

Ophthalmia Neonatorum

3 per 1,000.

Medical aid was sought in 18 per cent of the cases (1920 in 16 per cent); this is very high but it is doubtless owing to the payment of the doctor's fee out of the rates. Forceps were applied in 22 per cent of the cases in which the midwife sent for medical aid.

This report seems to show that, granted time and money to extend this care to all parts of the country, the maternal mortality of England could be reduced to one and a fraction per 1,000 births, as has been done in Denmark through the midwifery practice there.

(To be continued in March)

Department of Student Nurses

Convener, Miss M. HERSEY, Royal Victoria Hospital, Montreal.

Advantages of Recreation to the Student Nurse

By AMY MARTIN WILSON, School for Nurses, Toronto General Hospital

Before discussing the advantages of recreation to the student nurse, we should determine just what is meant by the term recreation. It does not imply pleasure or sport only, but includes any type of activity which is in direct contrast to the activity in which one has been daily engaged. A certain amount of recreation is as essential as work, for without recreation, really good work cannot be done. Proper recreation should be the means of providing good health, renewed interest in work from day to day, a broader outlook on life, a more companionable disposition and various other advantages.

Nurses seem to be a class, who, as a whole, are apt to neglect recreation. They become so absorbed in their work that other outside interests are gradually forgotten, friendships are broken and soon they become entirely wrapped up in what concerns the hospital and it alone.

Recreation has many forms and it should not be difficult for any nurse to obtain the proper amount in various ways. Too much recreation can be just as harmful as too little, but the sensible nurse will study her own needs for sleep and study and suit her hours of recreation to this.

As our first example of one form of recreation, we shall take outside social activities and the keeping up of old friendships. When a nurse withdraws from her former circle of acquaintances and her social set, associating only with other nurses, she quickly loses some of the charm of being the congenial companion she was heretofore and has no interests to think about outside her profession. Her outlook on life is narrowed, she sees things only from the standpoint of those around her and she is not so bright and cheery as the nurse who cherishes a lively interest in outside happenings.

What every nurse needs is to get away for a few hours in the afternoon or evening, to mingle with her old friends and to forget her work, with all the petty worries and cares she may have had through the long day. The strain under which she may have been working is relieved, her interest revives and then she comes back to her work with greater courage to bear up under difficulties and discouragements and with a brighter, happier face to cheer her patients. The nurse who neglects her friendships soon becomes the mechanical worker to whom nursing means nothing but doing what she has to do in as short a time as possible. Her interest is gone and no true success can be won if she has no heart for her work.

Another form of recreation is reading. This has the double advantage of affording physical relaxation, at the same time educating and training the reader's mind. It has been truly said that good books are close companions. Nurses not socially inclined, could derive recreation from this source. Books stimulate thought, they impart to their readers the wisdom and experience of greater men and women and are a vast source of education for those eager to learn.

The newspapers must not be forgotten either. Canadian nurses have no excuse for not being as good

citizens as other Canadian women. But how many nurses are even aware how the Government of their country is being carried on, and how can they vote, independently and wisely, when they have not kept up with the state of affairs even in their own community? Nurses, almost above all women in professions, since they are held in such high esteem, should be examples of good citizenship and not be so neglectful of political matters that they cannot or will not intelligently exercise the franchise.

Executive ability is an enviable quality for anyone to possess. It would be of great va ue to a nurse undertaking an institu_onal position. Although usually a gift to be born with, executive ability has been developed with determination. Some nurses might care to keep in touch with societies to which they belonged before entering the hospital. Their time should not be so limited as to prevent this. There is an excellent training to be had for anyone who is an officer of even a small organization. Then, too, in every hospital there is at least some kind of society for its nurses. It may be literary, or athletic and may include perhaps the whole school or only interested members. Some training schools have now adopted the system of Student Government, which although only a recent innovation, seems to be a success wherever the student nurses have taken a whole-hearted interest in its progress. Officers of these organizations in large hospitals have done much in the way of demonstrating its value to smaller schools and although great demands are made on the time and energy of a nurse, she is well recompensed for her efforts. She is trained to speak before an assembly, to develop any executive ability she may possess and to create ability and confidence where it is lacking. She learns, also, decision and independence of thought and action, assets which are too valuable to be estimated in words.

Lastly, physical recreation must not be neglected. The nurse who realizes that recreation is necessary to good health, will wisely see to it that she does not neglect it daily and will be repaid by a healthier appetite, a clearer brain, a keener zeal for work and a sweeter disposition.

In conclusion, we might say that recreation is not a side-issue; not an "extra" but an essential, and its many advantages cannot be too strongly emphasized. "All work and no play" may eventually bring material success but it will make of life a continual grind, while the true success that comes with love of work and a keen interest in life, is achieved by those who have the good sense and far sightedness to keep their minds and bodies fit that they may bring honour and success to the profession which they have chosen.

A Prescription

I went to Dr. Sense to-day. "I'm feeling ill," I said. "My feet are cold as potter's clay, and burning is my head. I have no energy at all. I'm blue as I can be. Oh! everything in life doth pall. I'm filled with misery. The world is like a giant foe that threatens me with death, and blocks my way where e'er I go, so icy is his breath. Despair and failure are my friends, they hold my heart in thrall; athwart the path where kind Love wends, I found a high stone wall." Then Dr. Sense rose from his chair, looked in my jaundiced eye, and laid my inky heart quite bare, and said with scornful sigh: "There's nothing wrong with you, my dear, except your point of view. Please take this bottle of Good Cheer and see what it will do!"

WILHELMINA STITCH.

News Notes

ALBERTA

EDMONTON

Members of the first class to graduate from the University Hospital were awarded diplomas and prizes at the graduation ceremonies held in Convocation Hall on Friday evening, December 10th, 1926. The graduating class, in white uniforms and black academic gowns, took the oath of service and filed before the university officials to receive diplomas and inscribed nursing pins in recognition of achievement. The graduating class were: Misses Josephine Henry Bulyea, Nora Margaret Glanville, Maud Elizabeth Inkin, Hazeleen Manuel, Viola Purcell, Eileen Eustace Ringwood, Annie Craigmyle Robertson, Isobel Secord, Carthena Evelyn Trowbridge, Mabel Edith Trowbridge, Aileen Beatrice White and Doreen Lenore Wood. Chancellor Beck welcomed the graduating class to convocation and presented the diplomas. Dr. Tory, president of the university, in his convocation address, said he had looked forward to this event of the graduation of the first class in nursing of the University Hospital for a considerable length of time. He mentioned the various "first occasions" which have followed each other in rapid succession since the first university convocation was held in 1908. Many hours of careful consideration had been spent before the hospital had been taken in charge, and there had been many difficulties in the way. The university officials were proud of the work that has been done. At the close of Dr. Tory's interesting address His Honour Lieut.-Governor Egbert spoke briefly, dealing with the qualifications of the nursing profession. Miss Isabel Secord was awarded the prize for general proficiency. The prize for highest standing in examinations was won by Miss Carthena Trowbridge. Miss Annie Robertson received honourable mention. Miss Kathryn Mallory, of the intermediate year, was given honourable mention. At the conclusion of the ceremony an informal reception was held in Convocation Hall, where the graduates met and received the congratulations of their friends.

Miss Elizabeth G. Fraser, Royal Alexandra Hospital, Edmonton, 1926, has accepted a position on the staff of the Kerrobert Municipal Hospital, Kerrobert, Sask.

BRITISH COLUMBIA

The results of examination for registered nurses' certificate held November, 1926, in hospital training schools of British Columbia are as follows:—

First Class—I. Kirkpatrick, Vancouver General Hospital; A. Jenkins, Kootenay Lake General Hospital, Nelson, B.C.

Second Class—G. Hunter, L. McCall, A. Castell (equal), J. Hocking, F. Doherty, M. de Fallot, M. Williams, M. Plumb, F. Campbell, F. E. McDonald; A. Bose, M. Spurr (equal); J. Marr, D. Miller, E. I. Spain, S. Palmborn; W. Chess, A. Mobley (equal); E. A. Homfrey, E. Kent, W. Neen, W. G. Calvert, V. Ternan, N. L. Draught, G. Temple, M. A. McDonald; I. N. McPhee, P. Rolfe, A. B. Duncan (equal), B. Hare.

Passed—M. Senkler; K. A. Townsend, A. M. McRae (equal); N. Meagher, J. Wilson, E. R. Collins, M. Neff; E. Haggart, I. Beastall (equal); D. Thompson, M. C. Radford; E. Cullimore, H. Olsen (equal); I. McGillivray, G. M. Potts (equal); G. Erickson, M. Douglass, E. S. Morrison, E. M. Olsen, M. Evemy, E. Duckworth.

Passed with supplementary to write in Anatomy—O. Minton and V. Doig.

CRANBROOK

St. Eugene's Hospital

Miss F. McIntosh, matron of the Hospital St. Maries, Idaho, recently passed through town on her way to spend a month's holiday in Nova Scotia. Miss T. Carlson, 1923, is substituting for Miss McIntosh.

Miss T. Chelmick, 1925, and Miss H. Hallbauer, 1926, have returned from Los Angeles, where they have been engaged in private duty nursing.

Miss S. Diebolt, 1926, has accepted a position on general duty at St. Mary's Hospital, New Westminster.

Miss May Williams, 1926, spent the Christmas holidays at her home in Invermere.

Miss A. Parneby, 1924, has left for California to join her sister, who is engaged in hospital nursing.

Miss H. Randal, provincial registrar, recently paid her annual visit to the school and delighted the students with an account of her visit to Ottawa at the time of the unveiling of the memorial in August.

Dr. Green, who has recently returned from the Mayo Clinic, has resumed his lectures on Obstetrical Nursing.

VANCOUVER

Vancouver General Hospital

The regular meeting of the Alumnae Association was held on Tuesday, January 4th, in the Nurses' Home. It was decided to postpone the election of officers until the next meeting as so many of the

members were either ill or had illness in their homes, making attendance impossible. The annual party of the graduating class was also postponed.

Miss Edith McColl, 1918, has been in Vancouver for the Christmas holidays and is returning shortly to take charge of a Children's Hospital in Iowa.

Miss Helen Massie, 1926, who has been doing private duty nursing in Vancouver for some time, after spending a vacation in her former home in Grand Forks has now left for Republic, Wash., where she has accepted a position in a hospital.

Miss Gladys Johnson, 1920, has returned to Vancouver after an absence of three years and is in charge of the Emergency Department of the General Hospital.

Miss Uyda MacDonald, 1925, has returned to Regina after spending the holidays at Vancouver.

Miss Julia Gibson, 1920, who has been at the Hollywood Hospital for the last two years, has now returned to Vancouver and is at present on the staff of the General Hospital.

Miss Helen Lumsden, 1919, after spending several months as the guest of her sister, Mrs. Bruce, of Victoria, B.C., has left for Pasadena, Calif.

MANITOBA

BRANDON

The student nurses of the General Hospital held a very successful bazaar during the latter part of December, from which they realized over three hundred dollars. Part of this sum is being devoted to activities of the student body, while the remainder, amounting to $174,00, was donated to the Graduate Nurses Association for the quartz lamp fund.

The receipt of this sum completes the amount required for the purchase of a quartz lamp, which is being installed in the children's ward of the General Hospital as the gift of the Graduate Nurses Association.

Miss Dorothy Hawes, B.G.H. 1925, left shortly after Christmas for Manila, Philippine Islands, where her marriage to Dr. Dwight Johnson (formerly interne at the General Hospital) will take place upon her arrival.

Mrs. J. Keating, of Poole, Ont., class 1908, is renewing acquaintances in Brandon.

Mrs. McGuire, nee Lulu Whichelo, B.G.H. 1912, has returned to Brandon to reside.

Owing to disturbed conditions in China, it is hoped that Miss Susan Haddock, of the province of Szechuan, whose furlough is due, will soon be welcomed home.

WINNIPEG

Miss Street, supervisor of Infants' Boarding Homes, fell at the New Year and fractured both the tibia and fibula above the ankle, and is confined to her home, following hospital treatment.

Another recent hospital inmate is Miss Olive Garland, in charge of the Deer Lodge Convalescent Hospital, who has had considerable sinus trouble, but is now much improved.

NEW BRUNSWICK

SAINT JOHN

Miss Mary Murdock has resigned her position on the staff of the Health Centre here to accept the position of assistant to the Director of Public Health Nursing in Wilmington, Delaware, U.S.A. Miss Murdock will be greatly missed in Saint John.

ONTARIO

BELLEVILLE

General Hospital

Miss Edith Wright, 1926, has accepted the position of supervisor of the private wards, B.G.H.

Miss Hilda M. Collier, 1921, supervisor of the operating room, has just completed a two months' course in the Bostline Free Hospital, Boston, Mass.

BRANTFORD

General Hospital

In place of the usual meeting, the Alumnae Association of the Brantford General Hospital entertained the Florence Nightingale nurses in the Residence on Tuesday evening, January 4th, 1927. Nurses from Paris and Simcoe were present. Musical numbers were enjoyed during the course of the evening and a dainty lunch brought an enjoyable social evening to a close.

HAMILTON

General Hospital

Miss Ella French is now in Chicago, where she will remain for some time.

Miss Lila Hack has accepted a position at the clinic of Dr. F. W. Mowbray.

Mrs. Rose Hess, who has been travelling in the Southern States for some months, is now at Houston, Texas.

Miss Ainslie left Hamilton for a trip round the world at the end of January.

Miss Julia Wood is relieving at the Dunnville Hospital for a few months.

TORONTO

Hospital for Sick Children

Christmas at the Hospital for Sick Children was as usual a day of wonder and joy for the little patients; a day crammed with trees, presents and fun. Santa Claus, accompanied by a choir of one hundred and thirty-two nurses, visited each ward, bringing happiness in his

wake. Nor were the nurses forgotten, for a beautiful radio was presented to them through the generosity of a member of the board of trustees, and it has been a source of untold pleasure ever since. The nurses themselves supplied Christmas baskets of cheer to ten poor families, to which the Alumnae Association contributed bread tickets.

On New Year's Day the cathedral choir of St. James made its twenty-ninth annual visit to the hospital, singing beautiful carols in the main corridor, the concert being broadcasted through the courtesy of one of the large radio stations.

An exceedingly interesting and largely attended meeting of the Alumnae Association took place on December 11th in the lecture room of the hospital, when Dr. Alan Brown, medical superintendent of the hospital, gave an interesting lecture on his trip abroad, illustrated by moving pictures. Dr. Brown was listened to with close attention and given a hearty vote of thanks at the close.

Miss Dorothy Fiske, 1926, has accepted the position of supervisor at the Children's Department, House of Mercy Hospital, Pittsfield, Mass.

Miss Mary Wheler is doing private duty nursing in Chicago, Ill.

Miss H. J. Johnston, 1926, has accepted the position of surgical supervisor at the General Hospital, Little Falls, N.Y.

Miss Barbara Spence, 1924, has taken a position in the X-Ray Department, Ottawa Civic Hospital, Ottawa.

Toronto General Hospital

On January 5th, Miss Maisie M. Noble, 1922, accompanied by Miss Mary B. Powell, a graduate of the Philadelphia General Hospital, started on what should be a most enjoyable and interesting trip, if the itinerary planned is adhered to. In a Dodge coupé they started from Terre Haute, Indiana, for St. Petersburg, Fla., and expected to reach New Orleans, La., in time for the Mardi Gras season. Several cities in Texas are to be visited, and the drive through California, Oregon and Washington to Vancouver, with a boat trip to Alaska, will give the travellers a wonderful opportunity for sight-seeing. The tour will be completed by driving through the Canadian Rockies, the Grand Canyon and Yellowstone Park. Since her graduation Miss Noble has been instructress of nurses at the Union Hospital, Terre Haute, Indiana.

Toronto Western Hospital

The annual meeting of the Alumnae Association of the Toronto Western Hospital Training School for Nurses was held in the Nurses' Residence on Tuesday, December 12th, 1926, when officers were elected for the ensuing year.

The annual Christmas tree in connection with the Out-Patients' Department was held with great success on Tuesday, December 22nd, 1926. Eighty children were entertained to Christmas dinner and each child received an article of clothing, a top, and a well-filled stocking. Dr. McLennan very ably acted as Santa Claus, and after the Christmas tree the children were entertained at a "Punch and Judy" show.

Miss Rahno Beamish has accepted a position as supervisor of the Obstetrical Department of the Warren General Hospital, Warren, Pa.

Miss Grace Ryde, 1921, has accepted a position as supervisor of the Nose and Throat Department.

Miss Eva Lynn, Miami, Florida, has been holidaying in Toronto.

Miss Marian Daly, New York, and Miss Mary Ogilvie, of the Red Cross Hospital, Thessalon, Ont., visited Toronto during the holiday season.

Miss Jessie Douglas, who has spent the last year in California, has returned to town.

Much sympathy is extended by the Alumnae Association to Mrs. Smith (Ruth Welstead) in her recent sad bereavement by the death of her mother.

A regular meeting of the Alumnae Association of the Department of Public Health Nursing was held on October 21st, 1926, at the Sherbourne House Club. This first reunion of the fall took the usual form: a business meeting followed by a welcome to the new class starting the course in public health nursing at the university. A very pleasing feature was the announcement that the objective for the giving of a scholarship in public health nursing, amounting to $400.00, had been reached, and that the scholarship had been awarded to Miss Myrtle Scott, a graduate of the Women's College Hospital, Toronto, who has been doing outpost duty at a Red Cross Hospital. Miss Kathleen Russell, director, and her assistant, Miss Emory, were present during the enjoyable social hour spent with the new class. Several delightful songs were contributed by Miss Fry, one of the members, and refreshments were served at the close of the evening.

Canadian friends of Miss Gwendoline Johnson, S.R.N., formerly mistress at Bishop Strachan School, Toronto, will be interested to learn that Miss Johnson has recently been appointed matron of the General Hospital at Saffron Walden, England. Miss Johnson is a graduate of the London Hospital and holds her C.M.B. and Health Visitor's certificates, and was formerly matron at the London Lock Hospital.

WINDSOR
Hotel Dieu A.A.

On Thursday evening, December 16th, 1926, the Alumnae Association met in the class-room of the Hotel Dieu Hospital. A lengthy discussion took place regarding the acceptance of undergraduate and practical nurses on the Essex County Registered Nurses' Register. The prevailing feeling was that after due consideration of qualifications, training (if any), etc., those able to give suitable references should be accepted. The practical nurses are to be asked to avail themselves of certain courses in Home Nursing now being given, as an opportunity to broaden their knowledge of nursing. After the officers for the ensuing year had been nominated and all other business disposed of, Miss Helen Jamieson, inspector of school nurses in Ontario, was presented to the members. Miss Jamieson gave a short talk on the growth of the Registered Nurses Associations in Ontario, the Provincial Board set for Training Schools and many other interesting topics. A social hour followed, refreshments being served by several of the nurses.

QUEBEC
MONTREAL
Royal Victoria Hospital

On New Year's Day Miss Hersey and her staff were at home to all Royal Victoria Hospital graduates and their friends. The guests were received by Miss Hersey, and the tea table, which was adorned with red roses and red unshaded candles, was presided over by Miss Hall and Miss Goodhue.

Miss Helen Richardson, 1922, is spending the winter in Augusta, Georgia.

Miss Marion Bate, 1926, is doing private nursing in New York.

Miss Mary Menzies, 1922, is in charge of a private floor in the Ottawa Civic Hospital.

Miss Irene Charlton, 1921, who is supervisor of the operating room at the Winnipeg General Hospital, has been visiting her friends in Montreal.

Miss Anne Slattery, 1920, spent the Christmas holidays in Port Morien, N.S.

C.A.M.N.S.
VANCOUVER

N/S Leila Brown, Euroa, Victoria, Australia, was the guest of honour at a delightful supper party held at the Pottery Gift Shop, on November 29th, 1926. Miss Brown served overseas with No. 5 Canadian General Hospital, being one of the original unit leaving Victoria in 1915. Those present at the supper and members of the same unit were: Miss J. Matheson, Miss E. Martin, Miss S. Heaney, Mrs. Heyer (Mary Cobb), Miss M. Quigley, Mrs. Mathews (Teddy Edwards), Miss A. Bruce, Miss E. Collis and Miss Mary McLane. Following the supper an enjoyable bridge party was given at the home of Mrs. Heyer.

Christmas greetings from Dame Maud McCarthy were received by the president, Canadian Nurses Association, for the Association; by Matron-in-Chief Macdonald for all overseas nursing sisters, and by Miss Jean Browne for all Canadian Red Cross Nurses and the Junior Red Cross. Greetings were also received by the president from the president of Nosokomos (Dutch Nurses Association) and at the National Office from the secretary at International Headquarters, Geneva, Switzerland.

From the Canadian Council on Child Welfare public health nurses may now obtain, free, any quantity of pre-natal letters, in English and in French, and Infant Mortality Statistical Wall Charts. The council will also supply at cost model layette patterns and abdominal and hose support patterns. Attractive coloured posters may be obtained at 75c per dozen, and sets of diet folders (five in number) are sold at 10c per set. In Ontario and Quebec the pre-natal letters are distributed from the office of the council, 408 Plaza Building, Ottawa. In Prince Edward Island, through Miss Mona Wilson, Red Cross Society, Charlottetown. In Nova Scotia, New Brunswick, Manitoba and Alberta through the council's office in Ottawa or through the Provincial Departments of Health. British Columbia and Saskatchewan publish their own letters, which are distributed through the Provincial Health Department.

Correspondence

Dear Editor:—

In renewing my subscription to The Canadian Nurse I must tell you how very much I think the magazine has improved. It has always given me so much pleasure in reading, but lately it seems to have grown broader and bigger. In a little out of the world sort of place like this, where one does not come in contact with the new things that are being done or those who do them, it is the greatest help to have such a magazine. I sometimes even pass it on to the doctor when there is an article which I think might interest him.

Thanking you for your helpful and interesting paper, and wishing you, and it, continued success.

(Sgd.) A. G. W.

To the Editor,
The Canadian Nurse.

May I be permitted to comment on the article in the November number of The Canadian Nurse, by Miss S. Caroline Ross, R.N., on The Ideal Method of Saving for the Trained Nurse.

Miss Ross accuses nurses of being improvident "like the men from the trenches." A few nurses may spend recklessly but they know, like the soldier, if disablement overtakes them they will be cared for by their family, as the soldier is looked after by his government. I do not think the average nurse extravagant—as a great many of us are called upon to help our families.

I do not agree with Miss Ross in her reference to the clothing needed by us. Personally I find uniforms an expensive addition to my wardrobe, the upkeep of which is considerable. We need out-of-door and evening clothes as other women. Also recreation and amusement, especially on account of our calling.

Life insurance is a good investment. A $5,000 twenty or thirty year policy would net a nurse about $325 per annum. Do you think the average person could live on this? If you wanted to borrow from the policy you would have to have carried the insurance a number of years before you could borrow anything substantial on it, for which the company would charge you 6%.

With all due respect to Miss Ross' article I am of the opinion that the best thing for registered nurses is to have a pension fund, similar to the school teachers, clergy, bank clerks and government employees. By paying into a fund of this kind, looked after by the government, when necessity arose we could draw sufficient to keep us comfortable.

(Sgd.) E. PODEEN MALCOLMSON, R.N.

BIRTHS

ANGELL—In December, 1926, at Vancouver, to Mr. and Mrs. Angell (Dorothy Mowatt, Vancouver General Hospital, 1924), a son.

APPLEBY—In December, 1926, at Vancouver, to Dr. and Mrs. Lyon Appleby (Margaret Lawler, Vancouver General Hospital, 1919), a son.

CARRUTHERS—On December 4th, 1926, at the Royal Jubilee Hospital, Victoria, B.C., to Mr. and Mrs. Carruthers (Winona Orr, Royal Jubilee Hospital, Victoria, 1912), a son.

DANIELS—In December, 1926, at Vancouver, B.C., to Mr. and Mrs. William Daniels (Irma Layton, Vancouver General Hospital, 1924), a daughter.

FRASER—On December 14th, 1926, at Springhill, Nova Scotia, to Mr. and Mrs. Harold Fraser (Margaret Davies, General Public Hospital, Saint John, N.B., 1914), a daughter.

HULL—On December 6th, 1926, at Cromwell, New Zealand, to Mr. and Mrs. Spurgeon Hull (Louise Raphael, Vancouver General Hospital, 1920), a daughter (Dorothy Louise).

TEDFORD—On December 17th, 1926, at Hotel Dieu Hospital, Windsor, to Mr. and Mrs. Cecil Tedford (Alma Beacom, Hotel Dieu, Windsor, 1923), a son (William Donald).

MARRIAGES

GORTON—ROWAT—On November 29th, 1926, Ann Reid Rowat (Royal Victoria Hospital, Montreal, 1916), to Dr. Levin Wailes Gorton.

MELVILLE—SMITH—On December 29th, 1926, at Rossland, Martha Smith (Vancouver General Hospital, 1926), to John Melville, of Vancouver. At home—Vancouver, B.C.

McKAY — TAITE — On December 23rd, 1926, at St. Giles United Church, Vancouver, Jessie Taite (Vancouver General Hospital, 1925), to Gilbert McKay, of Tisdale, Sask. At home—Tisdale, Sask.

PHILLIPS—WEILER—On January 1st, 1927, at Mildmay, Ont., Genevieve Weiler (Brantford General Hospital, 1925), to Reginald Phillips, of Brantford.

THOMPSON—KEIRSTEAD — On December 28th, 1926, at St. John, N.B., Rosa D. Keirstead (General Public Hospital, Saint John, 1918), to Victor Thompson. Mr. and Mrs. Thompson will reside in Milton, Mass.

WHITNEY—HEELEY—On December 8th, 1926, at Eildon Hall, Sutton W., Ont., Marjorie Ratcliff Heeley (Vancouver General Hospital, 1915), to Gilbert Simpson Whitney. At home—98 St. Paul St., St. Catharines, Ont.

WRIGHT—LAWSON—On December 29th, 1926, Mary Prescott Lawson (Royal Victoria Hospital, 1922), to Charles Wright, of Trail, B.C. At home—Trail, B.C.

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FLEMING—MITCHELL—On January 1st, 1927, at Toronto, Edith H. Mitchell (Toronto Western Hospital, 1921), to Oliver Fleming, of Brampton, Ont.

THE CANADIAN NURSE

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